STATE TITLE V BLOCK GRANT NARRATIVE
STATE: TX
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

As per the Title V Block Grant Guidance dated July 15, 2005, the appropriate assurances and certifications are being maintained in the Title V Director's office and are available upon request. Please call Fouad Berrahou and/or Shirley Broussard at 512-458-7321 if you have questions or need to view the assurances and certifications.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input on issues surrounding MCH/CSHCN continues to be an important component of the Title V program and its operations. Despite the abolishment of most Title V advisory committees by the 78th Legislature in 2003, Title V program areas have routinely used several mechanisms for soliciting public input. Different Title V programs regularly convene informal advisory committees, workgroups, focus groups, or other bodies to address diverse health issues, such as health disparities, integration of primary health care with mental health, and medical home. Several Title V program areas also have well-populated email distribution lists that are actively used to share information and solicit feedback relative to policy changes. In addition, most email distribution lists include advocacy groups and parents interested in Title V. Currently, several roundtables are organized across Texas with women's health providers to provide program updates and discuss impact of mandates from the recently completed 79th Legislature.

The Title V application development was made available to facilitate comment throughout the 5-year needs assessment, which reflect comprehensive knowledge gained through interactions with Title V stakeholders. After its transmittal, the application will be posted on the Title V website and a notice of its availability, electronically or in hard copy, will be sent to those stakeholders who participated in the 5-year needs assessment.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Department of State Health Services (DSHS), which administers the Title V program, operates within a structure defined by 11 Health Service Regions (HSRs) for the provision of essential public health services to all Texans. A map is attached (Attachment A) to serve as a reference throughout the application.

The purpose of the Texas Title V Program is to address the overall intent of the Maternal and Child Health (MCH) Services Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Texas has responsibility to provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations.

Texas' Title V Program operates within the strategic plan framework articulated by Texas State Government; the Texas Health and Human Services Commission (HHSC), the state agency responsible for leading and overseeing the health and human services agencies and ensuring that they function as a system; and the Texas Department of State Health Services (DSHS), the state agency responsible for administration of the Title V program. DSHS was newly established and began operations on September 1, 2004, as a result of the passage of House Bill 2292 during the 78th Legislative Regular Session in 2003. HB 2292 established a clear directive to transform the delivery of health and human services in Texas. The consolidation of 12 agencies into a network of four new departments under the leadership of HHSC was designed to improve services, increase efficiency and enhance accountability among the state's health and human service agencies. This act consolidated the programs of the Texas Commission on Alcohol and Drug Abuse, the Texas Department of Health, the mental health components of the Texas MHMR, and the Texas Health Care Information Council into a single department called DSHS. This consolidation has presented opportunities to integrate primary health care with behavioral health care effectively and to make health information more accessible.

DSHS administers both the MCH and CSHCN programs within the Division of Family and Community Health Services (FCHS). The CSHCN Services Program (CSHCN SP), Kidney Health Care Program, Hemophilia Assistance Program, and Anatomical Gift Education Program have been consolidated into the Purchased Health Services Unit within FCHS. In addition, this consolidation effort provided an opportunity to situate subject matter experts of women's health, child health, adolescent health, perinatal health systems, the Block Grant Administrator, as well as the Texas Primary Care Office staff under the oversight of the State Title V Director. Integration efforts are expected to continue well into FY 2006. As stated earlier, DSHS includes programs from the former Texas Department of Health as well as the state mental health and substance abuse service programs. Both MCH and CSHCN programs are already exploring opportunities for enhanced service coordination with children's mental health services staff.

This environment of change has been challenging yet stimulating to the Title V five-year needs assessment and annual planning process. As a result of these intra- and inter-agency organizational changes, Title V staff have an opportunity to work more closely with other programs and agencies (e.g. adult health care programs, mental health and substance abuse programs, and early childhood programs). HHSC has assumed a key role in leading cross-collaboration efforts among programs and agencies that serve children. While the stage has been set for enhanced collaboration, the immediate steps and adjustment involved in the consolidation have posed some challenges to communication and clarification of staff roles. The MCH and CSHCN staff will continue to work closely with DSHS leadership and HHSC, as well as with broad-based stakeholder groups, to promote progress toward the Title V performance measures throughout Texas.

The Title V program is an important component in achieving the Visions, Missions, Philosophies, and

Benchmarks for Texas' priority goal for health and human services. As outlined by the Governor's Office of Budget, Planning and Policy, this primary goal is to reduce dependence on public assistance through an efficient and effective system that promotes the health, responsibility, and self-sufficiency of individuals and families. The statewide benchmarks relevant to this goal are consistent with requirements of Title V program and Title V national outcome and performance measures. The relevant statewide benchmarks include: infant mortality rate; low birth weight rate; teen pregnancy rate; percent of births that are out-of-wedlock; incidence of vaccine-preventable diseases; rate of substance abuse and alcoholism among Texans, and number of surveillance activities and field investigations conducted for communicable disease injury or harmful exposure. The vision, mission, and driving principles of DSHS further support and strengthen the Texas Title V program.

DSHS vision statement: Texans have access to effectively delivered public health, medical care, mental health and substance abuse services and all Texans live and work in safe, healthy communities.

DSHS mission statement: The Department of State Health Services promotes optimal health for individuals and communities while providing effective health, mental health and substance abuse services to Texans.

We accomplish our mission by providing and supporting:
1. Essential public health services of:
- Surveillance, diagnosis and investigation of diseases, health problems and threats to the public's health.
- Education, empowerment and mobilization of individuals and communities to prevent health problems and improve their health status.
- Promotion of health policies and planning for individuals and community efforts to improve their health.
- Regulation and enforcement of public health laws and policies necessary to control disease and protect the public's wellbeing.
- Facilitating access to health services for individuals of greatest need.
- Critically evaluating and refining our public health activities and workforce competence.
- Supporting the health care safety net for children and adults with special health care needs, uninsured and underinsured people and families.

2. DSHS driving principles and values of:
- Sound Mind-Sound Body, which represents an integrated approach to health that demonstrates mind/body connectedness. What is good for the body is often beneficial for the mind.
- Prevention First Approach, which is critical to the public's health, it has never been possible to overcome an epidemic simply by treatment.
- Partnering and working together to improve access to and availability of care, reduce health disparities, and eliminate the stigma of mental illness, and to build a successful public health system.

At the core of DSHS' strategic plan are priority needs established in partnership with external and internal stakeholders and consumers, the former Board of Health, and DSHS executive managers. Through these priority needs, DSHS works toward strengthening the health status of individuals and enhancing public health systems in Texas. These six priorities focus on achieving a healthy Texas and are consistent with Title V program:

1. Improving Immunization Rates. Results of the 2003 National Immunization Survey (NIS) show that 78.1% of Texas children ages 19 months through 35 months were fully vaccinated in the 4:3:1 vaccine series, the highest level Texas has ever achieved. This figure represents a 9.5% increase (6.8 percentage points) over the previous year's 71.3%. While this an improvement from the previous year, Texas' vaccine coverage level has been lower that the national level since 1996. DSHS has the challenge of raising immunization levels through a collaborative effort that demands local involvement and the commitment of other state programs and agencies. This effort also requires the commitment of parents, businesses, and schools. To this end, DSHS has directed many of its efforts to build

community coalitions, educate medical providers about the importance of immunizations, implement the Texas' Immunization Registry ImmTrac, and raise public awareness through a $1.5 million advertising campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. The campaign includes billboards, radio, television and print ads in English and Spanish and focuses on selected areas with low immunization rates.

2. Promoting Healthy Eating and Regular Physical Activity. Overweight and obesity are associated with increased risks for several diseases including heart diseases and diabetes. Over one-third of adults in Texas were overweight in 2004. The prevalence of overweight children is far worse in Texas than in the nation as a whole. Further illustrating the priority of this issue in Texas, in 2002, Governor Rick Perry appointed an 11-member Advisory Committee on Physical Fitness to provide advice on issues relevant to physical fitness. The DSHS Commissioner was appointed to this advisory committee. At DSHS, several efforts are underway to educate individuals and communities about the benefits of physical activity and good nutrition. An example of these efforts is the Building Healthy Families Initiative. In cooperation with Blue Cross and Blue Shield of Texas, the Caring for Children Foundation of Texas, HEB grocery stores, Texas Medical Association, Texas Hospital Association, and the American Heart Association of Texas, DSHS launched this new initiative on September 5, 2004 for a fall tour of major Texas cities. The two-part purpose of Building Healthy Families is to raise awareness of the long-term health risks associated with obesity in adults and children, and to inspire small lifestyle changes that can lead Texans to live healthier lives through exercise and better food choices. This Initiative was based on the 2003 DSHS Strategic Plan on the Prevention of Obesity in Texas. As outlined in the strategic plan, the first step in the prevention of obesity is public awareness, and that is where Building Healthy Families Initiative comes in.

3. Promoting and Integrating Mental Health and Substance Abuse Services into Primary Health Care Setting. In 2002, 1.5 million Texans suffered serious mental illness impairing their ability to function at work, school, and in the community. Only 25% of persons with mental illness obtain treatment, while 60%-80% of persons with heart disease seek treatment. Furthermore, as many as 40% of persons with serious mental illness do not seek treatment. Yet the recovery rate for mental illness overall is significantly better than it is for heart disease. Substance abuse data are somber: about half of all crime in Texas is related to substance abuse and committed by individuals younger than 25. Consistent with the National Initiative to Improve Adolescent Health by the year 2010, DSHS and Title V program are examining several avenues towards improving access to and utilization of quality mental health (MH) and substance abuse (SA) services for children, including children with special health care needs, adolescents, and pregnant women (in particular those with low income or with limited availability of health services) through integration of MH / SA in primary health care settings. To this end, a workgroup was established, consisting of DSHS executive managers and other external stakeholders: 1) to increase awareness of and promote utilization of Children's Medication Algorithm Project (CMAP) among primary care physicians, educators and parents; and 2) to ensure adolescent behavioral health screening in every primary care setting in Texas. Currently, the workgroup is focusing on a few potential primary care sites, such as Title V-funded MCH contractors, FQHCs, and rural health clinics, to participate in the pilot designed to integrate primary health care with behavioral health care effectively.

4. Eliminating Disparities in Health Among Population Groups. In an attempt to address growing concerns about health disparities, the 77th Legislature passed HB 757 that established the Health Disparities Task Force. The task force is charged with consulting with DSHS: 1) to eliminate health and health access disparities in Texas among multi-cultural, disadvantaged, and regional populations; and 2) to reorganize DSHS programs to eliminate those disparities. The 2004 Annual Report of the Health Disparities Task Force to the Legislature focuses on five priority health issues: immunizations, obesity, tobacco, STDs, adequate prenatal care, and organizational programmatic and policy changes. Due to the recently completed health and human services consolidation, DSHS extends the public health framework to include mental health promotionsubstance abuse prevention, and the stigma associated with the treatment of mental illness and substance abuse to be more challenging. One challenge we now face is to address health disparities in a broader context. Some of the more striking disparities in mental health involve gender. Nearly twice as many women as men are affected

by depression each year and more women than men attempt suicide. Yet, four times as many men as women die by suicide. Eliminating health disparities in Texas requires a commitment to identifying and addressing the underlying causes of higher levels of disease and barriers to access services in racial and ethnic minority communities. DSHS is committed to removing differences in health status, which we believe are simply unacceptable.

5 & 6. Improving DSHS Ability to Respond to Disasters or Disease Outbreaks Whether They Are Intentionally Caused or Naturally-Occurring; and Improving the Efficiency and Effectiveness of DSHS Business Practices. Enhancing business practices and strengthening the state and local responsiveness to bioterrorism are two priorities for DSHS. As a tax-supported public service agency, DSHS is responsible for re-examining on an ongoing basis its business practices to assure proper stewardship of public funds. DSHS is committed to achieve all milestones included in its Business Improvement Plan by improving and establishing existing and new systems and controls for finance and accounting, budgeting, contract and grant management, and human resources.

Preparedness and response activities have become high priorities since the attacks of September 11, 2001. Ensuring a strong and flexible public health infrastructure is key to the ability of DSHS to react and protect Texans from both naturally occurring disease outbreaks as well as intentional threats, such as bioterrorism. DSHS is working with state, regional, and local partners to ensure a strong, flexible, and responsive public health preparedness.

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following demographic, economic, and social trends provide an overview of some of these important characteristics for Texas.
Demographic Trends. According to the State Data Center and Demographer, by the year 2010 Texas' population is expected to grow from the current 22.5 million to 25 million. The population could be more than 51.7 million in 2040. Projected growth under all scenarios would be substantial, and in excess of Census Bureau national projections for the 50-year period from 2000-2050. Areas with the highest level of population growth include the Texas-Mexico border, Texas' central corridor from Dallas-Fort Worth through San Antonio and the Houston-Galveston area. Slower rates of growth are seen in the Panhandle, West Texas and Beaumont-Port Arthur areas. It is interesting to note, given Texas' vast geographical area, that by 2005, non-metropolitan counties accounted for only 13.5% of Texas' total population (and accounted for only 12.1% of the population increase since 2000), while metropolitan counties accounted for 86.5% of the population (and accounted for 87.9% of the population increase). Texas' population is also seeing increasing diversification and aging. As compared to all the other states in the nation, Texas has the third largest Anglo population (11,327,876), the second largest African-American population (2,588,603), the second largest Hispanic population (7,820,842) and fourth largest population of persons from other racial/ethnic groups (818,706). Texas population, like that of much of the rest of the nation, will continue to age. By 2040, nearly 1 in 5 persons will be 65 years of age or older, as compared to fewer than 1 in 10 in 2000. The issues of aging and diversification of the population are also clearly seen in the relationship between youth-status and non-Anglo status. Sixty-one percent of Texas' population aged 5 years and younger and 59% of the total population less than 18 years of age are non-Anglo. Texas is ranked 45 nationally in the number of persons aged 25 and older who completed high school, and of the 1.2 million students in public high school in 2000, approximately 12.5% dropped out. Texas socioeconomic and service structures will continue to be challenged by a population that is larger, older, and increasingly diverse. The Texas population is expected to experience the emergence of a new numerical majority. Population changes, coupled with Texas' size and complexity, will challenge Texas' resources during this century.

Economic Factors. Continuing the trend of the last couple of years, Texas' unemployment rate remained stable, albeit higher than that reported just a few years ago. According to the Texas Statewide Labor Market Analysis, the seasonally-adjusted unemployment rate in Texas for February 2005 was 6.1% with rates ranging from a low of 3.2% in Shackelford County (Region 11) to a high of

18.6% in Maverick County (Region 8). Ten of Texas' 254 counties (3.9%) reported double digit unemployment rates ranging from 10.0 to 18.6. East Texas counties, as well as the Texas-Mexico border, continued to have significant problems associated with unemployment. Most forecasts on Texas' economic picture indicate that the Texas jobless rate may have peaked and will likely improve in the near future.

Current Poverty Rates. In 2004, 17.0% of Texas' population lived at or below poverty, showing an increase from the 14.7% reported in 2001. The issues of poverty continue to challenge state resources and impact overall health status. Hispanics were disproportionately the largest group living in poverty: among this group, the poverty rate was 59.8% in 2001, while they represented only about 35% of the general population. Anglos and others represented 26.4 of those living in poverty, and about 54% of the general population. African-Americans represented 13.8 of those living in poverty, but represent only 11.5% of Texas' general population. National estimates for 2003 indicate that 12.5% of the US population lives below poverty levels. The percentage of the population living below established poverty threshold is higher in Texas than in the nation (17% vs. 12.5%). However, poverty rates are lower in Texas compared with national rates for Anglos (7.3% vs. 10.5%) and Blacks (18.8% vs. 24.3%), and higher for Hispanics (25.2% vs. 22.5%). In Texas, those aged less than 18 years of age represent 41.6 of those living poverty, while those aged 65 plus represent 8.4% of those living in poverty. Forty-three percent of the total population living in poverty is employed, approximately 8.9% are unemployed, and 47.9 % are not in the labor force. Forty-nine percent have less than a high school education, with only 7.9% reporting a college or higher-level degree. Over 42% of those living in poverty have either both parents or the mother present in the home. Health care coverage remains a critical need for those living in poverty. According to the same reports, only 57% of those living in poverty in 2001 reported having some health insurance coverage during 2000.

Texas Health Insurance Coverage Rates. Many national sources continue to report that Texas has the highest rate of uninsured persons in the U. S. One out every 10 people without insurance in the U.S. lives in Texas. In 2003, the last year for which full year data is available, 5.5 million Texans or 24.6% of Texas' total population were uninsured. 2003 CPS estimates that 38.6% of Texas' Hispanics and 22.7% of Texas' African Americans were uninsured. Further, they estimate that 21.5% of all children under age 18, and 24% of all Texas women go without adequate or with no health insurance coverage. Educational attainment for this population is consistent with those reporting poverty status, with 38.3% of those without health insurance having less than a high-school education and approximately 10.7% reporting a college or higher-level degree. Of those without insurance, 26.5% report being employed. Addressing these issues relative to the uninsured and underinsured is a critical factor in improving maternal and child health outcomes. Work is ongoing on several levels to address this issue.

Texas Uncompensated Care. The rise of health care costs and the fall of rates of insurance over the past several years in Texas have resulted in fiscal pressure on both state and local governments. The cost of uncompensated care absorbed by health care organizations for persons who are uninsured or unable to pay for healthcare keeps increasing over the years. In Texas, total uncompensated care increased 114% between 1993 and 2002. In 2002, Texas ranked highest among the seven most populous states in total uncompensated care reported by hospitals ($6.1 billion), in per capita uncompensated care ($282.50), and in the ratio of uncompensated care to gross patient revenue (8.2%). Several options are being examined to address the burden of uncompensated care. Those options can be summarized into the following broad categories:
State initiatives to expand private health insurance coverage;
Expansions of governmental insurance programs;
Expansions of provider-based care, such as Federally Qualified Health Centers;
State reimbursement systems for providers who incur costs; and
State facilities that provide care for indigents, such as the University of Texas Medical Branch at Galveston or the Texas Center for Infectious Disease.

Health Professional Shortage Areas. Any reports addressing maternal and child health status in Texas must include a discussion on health care providers as there is a direct correlation to access to

maternal and child health services and the availability of providers providing those services. Provider shortages in the state continue and, in part, frame the state's ability to impact maternal and child health status. In FY 2005, 51.6% or 131 of Texas' 254 counties are designated as HPSA for primary care and 79, or 31.1%, are designated as HPSA for dental care and treatment. The number of Medically Underserved Areas (MUA) remained stable at 177, while the number of partial county MUAs slightly increased to 88 (in 47 counties). Texas currently has 64 local health departments that receive state funding and approximately 78 local health departments that do not receive state funding. Of the 254 counties in Texas, approximately 150 (or 59%) have no local public health presence but receive public health services by DSHS regional offices.

Key Initiatives and Summary of the Legislation Relating to Maternal and Child Health, including CSHCN.
Key initiatives for CSHCN have begun in improving medical home services. Following an initial statewide kick-off conference in October 2003, there has been growing interest and awareness among stakeholders. A statewide Medical Home Workgroup has been formed with regular meetings. The group has developed a strategic plan and provides continuing guidance to statewide efforts. The state applied and was accepted into the national Medical Home Learning Collaborative II. A state-level team works with three practice teams serving as medical home models. Paralleling the Medical Home Workgroup, the CSHCN Services Program (SP) has established a Transition Workgroup, which has met several times and has a strategic plan. These groups planning efforts along with the strategic plans and initiatives of other formally established stakeholder advisory groups have been folded into the Title V CSHCN five-year needs assessment and planning process. In addition, since the CSHCN SP no longer has a formal CSHCN Advisory Committee, the program actively looks for ways to engage stakeholders in the decision-making process. The program has strengthened ties with the Texas "Parent to Parent" organization and collaborates with their Champions for Progress grant. Parents of CSHCN in various geographic locations in Texas have become Family Voices representatives to improve statewide involvement of families in systems development. Regional social work staff and the program's community-based service contractors work to facilitate family access to services, promote family networking, increase family involvement in community service system development decisions, and obtain family feedback.

On the MCH side, several initiatives are being implemented in collaboration with other public and private partners to improve access to and availability of care and to focus on prevention and education to prevent health problems and improve health status of the women and children in Texas. Examples are: 1) enhancing Texas's capacity to coordinate and integrate service delivery for all children under 6 years old; 2) providing local health care organizations with state funds to develop business plans and the infrastructure and capacity required of FQHC organizations (the initiative has resulted in more than 20 new or expanded existing FQHCs since its inception in FY 2003); 3) expanding the number of disorders screened in Texas and planning for the infrastructure and capacity required to serve newly identified children that will need confirmatory testing and follow up care; and 4) increasing access to mental health and substance abuse services for adolescents through a pilot project in which primary care physicians, family practitioners, and other medical professionals will be trained to screen, assess, and prescribe medicines to adolescents with minor mental health disorders and substance abuse problems.

The 79th Legislative Regular Session ended on May 30, 2005. DSHS tracked over 600 bills this session. DSHS staff analyzed and prepared fiscal notes for these bills, and many staff also served as resource witnesses at committee hearings. At the close of the 140-day session, less than 200 bills remained on the DSHS list. The information below provides a high-level summary of legislative bills impacting maternal and child health. Title V program plays an important role in assessing the impact and addressing the intent of each bill.

- Senate Bill (SB) 316: Requires DSHS to create an informational brochure about Shaken Baby Syndrome, perinatal depression, newborn screening, and immunizations, which would be posted on the DSHS website. The bill also requires that all hospitals, birthing centers, and midwives present new parents with written or verbal information about Shaken Baby Syndrome shortly after their child's birth.

The bill also requires DSHS to make a printed version of the pamphlet available to physicians.

- House Bill (HB) 790: Requires DSHS to expand the number of disorders for which newborns are tested, to determine whether the activity should be outsourced, and to plan for the expansion to the full number of tests recommended by the American College of Medical Geneticists.

- SB 419: Prohibits a physician from performing an abortion on an unemancipated minor without the consent of the minor's parent, guardian or managing conservator, or without a court order as provided under Chapter 33, Family Code. Title V currently produces and distributes informational materials that explain the rights of a minor under Chapter 33, which requires parental notification for abortion. The materials will be updated to include the new consent provision. DSHS also reimburses counties for the cost of judicial bypass proceedings, if the counties request it.

- SB 747: Requires HHSC to create a Medicaid waiver program expanding eligibility to women living at or below 185 percent of the federal poverty level for preventative health and family planning services, increasing access to these services and allowing the state to draw down additional federal Medicaid funding.

- HB 2475: Requires DSHS, in conjunction with the Cancer Council, to develop a strategic plan to eliminate mortality from cervical cancer by the year 2015. The strategic plan must take into account barriers to screening, current technologies and best practices, and identify gaps in service, and must be submitted to the Governor and members of the Legislature by December 31, 2006.

Texas Medicaid Program
Medicaid is a jointly funded state-federal program, established in Texas in 1967 and administered by HHSC. As of January 2004, there were 2,501,804 Medicaid recipients in Texas, as opposed to 2,683,168 recipients in June 2005, representing an increase of about 2%. Of these Medicaid recipients, 1,814,940, or approximately 68%, are aged 0-18. The Medicaid caseload indicates that about one in nine Texans (2.6 million of 22.5 million) relied on Medicaid for health insurance or long-term care services. Non-disabled children make up the largest share (64%) of Texas Medicaid clients. Of the 1,814,940 children 18 years old and younger enrolled in the program as of June 2005, about 1,732,551 (95%) were receiving TANF or SSI cash payments. Medicaid funds slightly above one-half of all births in Texas. In FY 2004, Medicaid paid for about 53% or 203,083 out of 379,671 births. In FY 2004, over half (56.6%) of the pregnant women in the Medicaid program are between the ages of 18 and 24. While private insurance companies can no longer exclude pregnant women seeking health insurance, many young pregnant women are less likely to be able to afford insurance. They are also more likely to work at low-level jobs that do not provide health coverage.

Texas currently provides services under the Medicaid managed care program in several service areas of the state, primarily centered in major metropolitan areas. These service delivery areas cover 43 counties. As of July 2002, a total of 767,581 clients were enrolled in Medicaid managed care. These clients were enrolled in either a health maintenance organization or the Primary Care Case Management (PCCM) model. As of July 2002, 66% of clients were enrolled in HMOs and 34% were in the PCCM plan. HB 2292 of the 78th Legislative Regular Session in 2003 directs HHSC to expand managed care throughout the state in order to obtain additional cost savings.

The expansion plan includes two managed care models: the fully capitated HMO model and a Primary Care Case Management (PCCM) model. In both models, members have a medical home through a primary care provider (PCP), from whom members receive primary care and obtain referrals to specialty care. In the HMO model, HMOs receive premiums from the state and pay providers negotiated rates to provide services to enrollees. In the PCCM model, PCPs receive a fee of approximately $3.00 per member per month from the state for acting as the PCP for their Medicaid managed care patients, and provider claims are paid on a fee-for-service basis through the state's Medicaid claims administrator. Following are key elements of the expansion:
1. For acute care Medicaid (primarily serving low-income pregnant women and children):
The HMO model will be implemented in one new service area consisting of Nueces and eight

surrounding counties (Health Service Region 11).

The PCCM model will be implemented in all remaining counties (197) without an HMO model. The implementation is on schedule for September 1, 2005. Through a transitional plan, the PCCM model will not be available in the new HMO service area and will be phased out of existing HMO service areas.
2. For integrated acute and long-term care Medicaid (serving aged and disabled Medicaid eligible clients):
The STAR+PLUS program, which is an HMO model that includes both acute and long-term care services, will be expanded to operate in all service areas in which the HMO model for acute care services will be available.
The recently completed 79th Legislative Regular Session appropriated about $26.4 billion for Medicaid programs for the 2006-2007 Biennium. This represents an increase of $4.9 billion in all funds. This funding anticipates increases in clients; restores certain services to adult Medicaid recipients; partially restores the Medically Needy Program; develops a comprehensive Medicaid education campaign for both providers and recipients; improves data analysis and reporting, and streamlines administrative processes; creates a Medicaid buy-in program for working individuals with disabilities who would qualify for Medicaid except for their earnings; establishes a five-year demonstration project to expand access to preventive health and family planning services for women 18 years and older; addresses cost growth in the program; and restores reimbursement rates to, or increases rates above, FY 2003 levels for long-term care services.

Title XXI: Children's Health Insurance Program (CHIP)
With the passage of Title XXI, Texas began planning and implementation of a state children's health insurance program. Texas CHIP is a state-designated program targeted to children ages 0 through 19 years of age at or below 200% FPL who are not otherwise eligible for Medicaid. Texas also covers legal immigrant children who are ineligible for CHIP under federal law because of their immigration status. Because these children are not eligible for the federal CHIP match, their coverage will be financed solely with state revenue.

Due to planned changes in the federal funding for state CHIP and other budgetary concerns, the 78th Texas Legislature in 2003 directed several significant changes in Texas CHIP policy. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100 percent of the FPL and cost-sharing for families below 185 percent of the FPL; 3) elimination of income deductions for items such as child care costs; 4) implementing a 90 day waiting period for coverage; and 5) several specific exclusions also were made from the benefit package and include dental, chiropractic and allergy services; vision care; and eye glasses. After these policy changes were implemented, the number of children enrolled in CHIP in Texas declined from 507,259 in September 2003 to 326,809 by May 2005, or about 36%. Texas CHIP reports that the three largest reported reasons for disenrollment are failure to complete the renewal process (38% of all disenrollment), mid-term status change resulting in enrollment in Medicaid (24% of all disenrollment), and families found ineligible after submitting renewal application (18% of all disenrollment). Any reductions in caseload in CHIP coupled with changes in Medicaid continue to impact negatively Texas Title V program's recipients.

However, the effect of these changes in eligibility requirements on enrollment should be viewed in a historical and national context. Prior to this decline in enrollment, Texas had engaged in aggressive outreach efforts to increase the number of children enrolled. In the first year of operation, the Texas CHIP program grew to cover over 300,000 children, and by year two it covered over a half million children. Also, the decline in enrollment in Texas occurred during a time when the federal funding for SCHIP was decreasing and when many states were experiencing fiscal constraints. The decline in Texas' enrollment coincided with those of 11 other states and the District of Columbia. Similar to Texas, many states implemented SCHIP policy changes that impacted enrollment.

Although disenrollment from CHIP in Texas and in other states could be the result of changes in employment, income, access to employer-sponsored insurance, or other factors, there is a concern

among advocates and policy analysts that administrative barriers, such as re-enrollment procedures, increased cost-sharing, and confusion among parents of enrolled children are significant causes of disenrollment. As a result, an analysis of disenrollment patterns in Texas CHIP was conducted by surveying families. The major findings are the following:
- Of those children who disenrolled from CHIP, the distribution of race and ethnicity is very similar, indicating that there was no disproportionate disenrollment of any particular racial or ethnic group.
- the majority of those families who obtained coverage for their children post disenrollment enrolled their children in Medicaid, thus, remaining on a public insurance program.
- Fewer Hispanics (40%) obtained insurance upon disenrolling when compared to White non-Hispanic families (57%) and Black non-Hispanic families (56%).
- The disenrollees' age is another potential area of concern. Children who disenrolled were somewhat older than those remaining enrolled.
- Eighty-eight percent of families were aware of the renewal process and 80% thought the process was easy.

When developing future policy, HHSC should consider the following strategies to: 1) increase outreach and education efforts with Hispanic families; 2) coordinate efforts between CHIP and Medicaid programs since a small percentage of families indicated that they had no coverage because they were told they qualified for Medicaid but later found out they were not eligible; 3) encourage parents of healthy children to maintain insurance coverage in order for these children to access preventive care services, including early detection of health problems, vaccinations, and routine screening procedures; and 4) ensure adolescents maintain coverage since this age group is at high risk for morbidity and mortality due to risk-taking behaviors.

The recently completed Texas 79th Legislative Regular Session in 2005 appropriated $1.4 billion for CHIP. Funding covers projected increases in client caseloads, addresses cost growth, adjusts assumptions on client cost sharing, restores dental, vision, hospice, and mental health benefits. In April 2005, HHSC solicited competitive proposals from vendors to provide dental care services statewide. Vendor proposals were due June 15, 2005, and program staff will spend the summer evaluating the proposals to make a tentative award announcement in August 2005 for a starting date for services on December 1, 2005. In addition, pending approval by the federal government, CHIP coverage will expand to cover eligible children during the prenatal period. This expansion will provide prenatal care to women not eligible for Medicaid due to their immigration or financial status. If approved, a large percentage of the women currently receiving prenatal care under Title V will receive care through CHIP, freeing up funds to focus on other areas.

Movement of Children Between CHIP and Medicaid.
Once a child has left either CHIP or Medicaid, HHSC examines records for the following year to find out whether the child enrolled or re-enrolled in Medicaid or CHIP. The analysis of the movement of children between Medicaid and CHIP revealed that in FY 2004:
a. Of the 379,009 children who left CHIP, 158,378 or 42% enrolled in Medicaid and 73,980 or 20% re-entered CHIP during the next 12 months.
b. Of 887,224 children who left Medicaid, 91,090 (10%) enrolled in CHIP and 364,526 or 41% re-entered Medicaid during the next 12 months.

Data are not available to show the number of children who obtain private insurance after leaving CHIP. However, a telephone survey of families who recently disenrolled from CHIP, conducted in 2004, indicated that 16% of these children obtained coverage through employer-based insurance or other sources, such as the military.

B. AGENCY CAPACITY

I. MCH Population

Because the Title V program primarily provides MCH services through contracts with local providers, it is critical that the agency has the capacity to ensure that these providers execute competently. Three areas of the agency provide the staffing, policies and guidelines, training and technical assistance, and quality assurance needed to support providers. Two of these areas, the Preventive and Primary Care Unit (PPCU) and the Performance Management Unit (PMU), are located in the Family and Community Health Services (FCHS) Division. The third area encompasses the health services regions located throughout the state. PPCU oversees the development of clinical policies and operational processes to assist contractors in delivering clinical services. Medical consultant Dr. Janet Lawson, an obstetrician/gynecologist, provides leadership in the development and clarification of clinical policies and protocols for community health services programs. Other staff members maintain expertise in national health standards, guidelines and best practices and provide clinical and technical support services to contractors. The unit also develops and implements professional education opportunities for clinical and administrative contractor staff to support service delivery. Clinical staff review and approve local clinical protocols, standards and procedures and provide support to required advisory committees, such as the Information and Education Committee for Family Planning and the Advisory Committee for Breast and Cervical Cancer Control.

The PMU has primary responsibility for quality assurance (QA) and quality improvement (QI) activities for contracted community health services, including Title V-funded services. The QA activities ensure that contractors comply with program rules, policies, and procedures for clinical and administrative areas. The QA site visits are based on risk assessments, and contractors are required to submit corrective action plans for areas found to be out of compliance during the review. Within the PMU, Quality Management Branch (QMB) staff coordinates the development of QA review tools. The QI activities focus on an analysis of QA results and outcomes. Common performance problems are tracked and reviewed with relevant staff. Research is conducted for national community health services standards, and staff develops QA targets for performance issues to assist with contract management and to ensure that quality services are provided.

DSHS and the Title V program operate within a structure defined by 11 health service regions for the provision of essential public health services to all Texans. The Title V program funds several positions based in regional offices to provide: 1) public health services, including core public health services and direct health care, in areas with no local health department (141 out of 254 counties have no public health presence); and 2) technical assistance, contract management, and quality assurance and quality improvement activities for all Title V-funded providers in their assigned regions. Consistent with Title V priority needs and related activity plans for FY 06, Title V program areas work with each public health region to develop, implement and monitor service level agreements (SLAs) in the areas of population-based services, quality assurance, vision and hearing, contract monitoring, and direct services. Each SLA amounts to a contract between the State Title V Director Office and each PHR and provides quantifiable time-specific performance measures, activities, and outcomes that each

Title V-funded public health region agrees to complete during specified timelines. Title V central and regional work together to develop and finalize the SLAs.

A number of overarching programs areas exist within DSHS to provide infrastructure and support for Title V service delivery. With the reorganization of the agency came three new offices, the Center for Policy & Innovation, the Center for Program Coordination and the Center for Consumer & External Affairs.

The essential functions of the Center for Policy & Innovation (CPI) are to provide organizing frameworks for service and policy innovation at DSHS. This includes establishing frameworks for inter-agency collaboration and rules development, review and revision. CPI responsibilities include developing methods that allow integrated funding across programs to provide cohesive services targeted to specific populations; facilitating a consistent communication bridge with agency leadership; increasing meaningful consumer involvement to broaden the range of possible partnerships; and building systems of care focusing on customer needs.

The Center for Program Coordination (CPC) strives to improve the overall performance of DSHS as well as the connections between the agency and its employees. Central to this work is the DSHS Workplace Improvement Plan, which focuses on agency strategic priorities in three areas--attracting and developing the best public health and behavioral health services; encouraging innovation and results-oriented government performance; and engaging employees in improving agency business and program practices. CPC has four primary functions. The first is program integration and coordination within DSHS and the HHHS umbrella and other related state agencies. The second is business process improvement, including mapping agency business practices, making recommendations for improvements, ensuring the use of consistent standards and practices, training on project management tools; and evaluating and maintaining benchmarks for department operations and service delivery. The third is leadership and management development, and the fourth is workplace improvement, including implementing the DSHS Workplace Improvement Plan.

The Center for Consumer & External Affairs (CCEA) provides centralized support to the DSHS Advisory Council; maintains stakeholder relations; provides a central location for public input; evaluates and analyzes customer satisfaction; and coordinates responses to inquiries to DSHS and among other health and human service agencies. The Center also serves as the liaison for governmental affairs, analyzes legislation; processes consumer complaints; and coordinates responses to media inquiries.

Additional program areas that provide systems capacity to Title V include: the Birth Defects Epidemiology and Surveillance Registry; the Promotora/Community Health Worker Program; the Laboratory Facility; the Center for Health Statistics; the Office of Border Health; the Office for the Elimination of Health Disparities; and the School Health Network.

The Birth Defects Epidemiology and Surveillance Registry collects data on birth defects throughout Texas. The data are used to identify patterns and differences around birth defects and the affected populations, conduct cluster investigations, contribute to national data collection efforts, evaluate potential environmental hazards and provide referral information for children and their families. The Research Center fosters collaborative research in finding preventable causes of birth defects.

In an effort to build an effective, culturally competent public health workforce, the 77th Texas Legislature codified the training and certification process for becoming a promotora/community health worker. Promotoras provide outreach, health education and referrals, often in a peer environment. The DSHS Promotora Program was charged with developing and operating the training and certification processes. At this time, there are 500 certified promotoras operating in 53 counties with all but one HSR represented. Use of promotoras is an emerging best practice for health education and counseling, and is a widely accepted means of disseminating maternal and child health information.

The DSHS laboratory facility conducts tests for large health screening programs and for public health programs, including clinical testing for infectious diseases and environmental testing for chemical contaminants. Routine activities include providing laboratory testing for the newborn screening program, the Texas Health Steps Program, and women's health services including cervical cancer screening; providing prenatal screening to determine the risk of Down's Syndrome, Trisomy 18, and neural tube defects. The laboratory provides selected clinical testing free-of-charge to all Title V-funded providers.

The Center for Health Statistics (CHS) is the DSHS focal point for the collection, analysis and dissemination of information to improve public health in Texas. CHS evaluates existing data systems; defines data needs and analytic approaches; adopts standards for data collection and dissemination; and coordinates, integrates, and provides access to specific CHS capabilities, including GIS; research design; health surveys; community assessments; and analytical methods. CHS coordinates and maintains health information web resources and responds to data requests. CHS also coordinates the collection and analysis of the BRFSS information for many Texas communities. The DSHS library, also part of CHS, provides health education and information services and resources to DSHS staff and consumers, including contractors.

The Office of Border Health (OBH) and the Office for the Elimination of Health Disparities (OEHD) provide critical support services for programs working to meet the needs of a state as populous and diverse as Texas. Thirty-two of Texas' 254 counties are defined as border counties. OBH is part of a bi-national effort to identify and prevent consumer, environmental and community health hazards along the Texas-Mexico border in coordination with local communities and U.S. and Mexican health entities. The Office promotes and coordinates public health issues with entities on both sides of the border; acts as the Texas Outreach Office for the U.S.-Mexico Border Health Commission; and works to inform, educate and mobilize community partnerships around health concerns.

OEHD supports the efforts of the Health Disparities Task Fore, created in the 77th Legislative Session, to eliminate health and health access disparities in Texas among multicultural, disadvantaged and regional population. The work of the OEHD and the Task Force has concentrated on six health topics: childhood immunization, obesity, physical activity and fitness, tobacco use, responsible sexual behavior and adequate prenatal care. In its 2004 report, the Task Force made a series of recommendations around each of these topics including increasing state funding and other resources to address them, expanding health promotion efforts and prevention programs and strengthening partnerships inside and outside DSHS. The Task Force also recommended maintaining the elimination of health disparities as an agency focus; the implementation of an internal workgroup for the elimination of health disparities; and the development of a cultural competency training program for DSHS staff and providers that could be replicated in other health and human service agencies. Both the OEHD and the Task Force work to guide and support DSHS programs in their efforts to eliminate health disparities related to their focus areas.

The Title V School Health Program supports the development of comprehensive school health education and school-related health care services statewide through two major program areas: school health network and school based health centers. The program provides start up grant funding for communities to establish school-based health centers to provide preventive and primary health care services on school campuses to a target population of medically underserved school age children and adolescents. In addition, the program funds the Texas School Health Network, which consists of a School Health Specialist in each of the state's 20 Regional Education Service Centers. The Specialists serve as a coordinating point and collaborative catalyst that promotes a healthy school environment and the healthy behaviors of all students and personnel. Many other programs within DSHS utilize the skills of the Specialists to promote their special initiatives but each Specialist tailors his or her program to concentrate on those needs/issues identified by the local school districts and the community.

II. CSHCN

CSHCN SP provides a comprehensive array of health care benefits (HCB) including: evaluation and diagnosis; physician visits; inpatient and outpatient hospital services; orthotics and prosthetics; medical equipment and supplies; nutritional supplements and counseling; medications; speech, language, physical, and occupational therapy; meals, lodging, and transportation to receive medical treatment; and family supports to CSHCN who meet a broad functional definition of "children with special health care needs," not just children with specific diagnoses, and adults with cystic fibrosis. The CSHCN SP provides health care benefits that are not covered by other third party payers. The program is the payer of last resort, after Medicaid, CHIP, and private insurance. The CSHCN SP enrolls and reimburses individual HCB providers throughout the state on a fee-for-service basis. Currently, due to budgetary constraints and the fact the CSHCN SP is not an entitlement program, the CSHCN SP continues to have a waiting list for HCB, which was instituted in October 2001.

CSHCN SP provides family support services (FSS), such as respite and vehicle and home modifications, to its health care beneficiaries. When there is a waiting list for HCB, as there is now, FSS is available only to CSHCN SP clients who are not on the waiting list and who are at risk of out of home placement or whose FSS coverage would result in cost-savings for the program.

At the end of February 2005, 827 CSHCN were on the waiting list for HCB. The number of clients on the waiting list varies due to the program's continuous receipt of applications and the removal of clients from the waiting list when the program's financial projections demonstrate the capacity to serve more clients. Budget alignment mechanisms have been put in place through the public rule-making process to enable the program to offer as many services as possible to individuals eligible for the program. Depending on budget projections, the program may offer limited services for limited time periods to clients on the waiting list for HCB.
In addition to HCB, the CSHCN SP annually provides extensive case management services throughout the state to more than 26,000 families and their CSHCN through DSHS Regional social work staff. Through service contracts with community-based organizations additional case management, FSS, and clinical care are provided to over 15,000 families and their CSHCN each year. Case managers (both staff and contractors) provide a critical statewide infrastructure for continuous efforts to: improve awareness of and access to the CSHCN Services Program health care benefits; coordinate state and community-based service systems; and achieve the Title V performance measures.

CSHCN SP staff work closely with other programs, agencies, organizations, stakeholder groups, and advisory committees/councils to improve the systems of care for CSHCN and their families and promulgate the importance of statewide collaboration to address and make progress toward the Title V CSHCN performance measures. Key stakeholder groups have addressed and incorporated the Title V CSHCN performance measures in their formal recommendations to the Texas legislature. Recent consolidation of programs within the former Texas Department of Health with the state mental health and substance abuse services to form the new DSHS offers an infrastructure and capacity that will facilitate increased collaboration among these programs and service delivery systems.

Culturally Competent Care
Current activities in all Title V program areas include an expectation that all staff have a working knowledge of cultural competence and the ability to conduct their work in a manner that shows consideration for racial and ethnic differences and for clients with physical, emotional and mental disabilities. People First language is used and all materials are made available in English and Spanish, and often other languages. Title V works to ensure cultural competence from its contractors through contract assurances, training and quality assurance monitoring. Title V Request For Proposals (RFPs) include a set of assurances and certifications towards limited English proficiency, interpreter services, and non-discrimination to which each contractor agrees to abide. Title V-funded contractors are supplied with a self-evaluation checklist for compliance with ADA/Section 504 policies and procedures.

Title V program areas staff also have access to translation services in the DSHS Center for Consumer

and External Affairs which reports directly to the Deputy Commissioner for Public Health Services. The Center for Consumer and External Affairs provides centralized support to the DSHS Advisory Council; maintains stakeholder relations and provides a central location for public input; evaluates and analyzes customer satisfaction; coordinates the referral of inquiries of divisions within the agency and among other health and human services agencies.

Most educational materials for children and women are published or made available in at least English and Spanish, and frequently in other languages based on need and demand. For example, the Genetics and Case Management program provides most of its materials in English and Spanish, and in collaboration with the WIC Program, Newborn Screening staff are provided access to telephone translation services to assist patients speaking languages other than English or Spanish. The Texas Toll-Free 2-1-1 Line is administered by 25 Area Information Centers (AICs) across the state. All of the AICs provide services 24 hours a day, seven days a week in multiple languages. In many cases, there are Spanish speaking operators. For the other languages, the AICs contract with either Tele-Interpretor or the AT&T Language Line. Services are also available through text telephone or TTY for the hearing impaired.
The CSHCN Services Program works proactively to ensure cultural competence. Bilingual (English and Spanish) and bicultural program staff operate a toll-free line for use by persons applying for and/or receiving the program's health care benefits. In addition, Regional case management and eligibility staff are bilingual. Regional offices also use Language Line Services to assist with communication in multiple languages other than English and Spanish. The program's written communications with its clientele are always done in both English and in Spanish, and the program also has many educational materials available in Spanish.

As part of its ongoing efforts, the CSHCN Services Program continues to seek opportunities to include input from statewide and regional groups and committees with family members who are both bicultural and bilingual. The program's service contractors are grassroots organizations serving communities throughout Texas and their leadership and advisory groups reflect the cultural make-up of the populations they serve. In 2005, the program is participating in the Medical Home Learning Collaborative II (MHLC) conducted by the National Initiative for Children's Healthcare Quality (NICHQ). Three medical practice teams participate. One team is located in Harlingen, Texas at Su Clinica Familiar. The Su Clinica team has helped with the Spanish translation of the family surveys used throughout the MHLC (in other states as well as Texas). Data from Su Clinica are helping to inform the MHLC of some of the cultural issues involved in providing medical home services to a largely Hispanic population. The participation of Su Clinica in the MHLC has heightened the awareness of MHLC, in general, to cultural and communication issues.

The state statutes relevant to Title V program authority and how they impact the Title V program are described in Attachment B.

C. ORGANIZATIONAL STRUCTURE

The Department of State Health Services (DSHS) is the state agency responsible for administration of the Title V Program and is one of four state health and human services (HHS) agencies under the umbrella of the Texas Health and Human Services Commission (HHSC). HB 2641 of the 76th Texas Legislature and HB 2292 of the 79th Texas Legislature enhanced HHSC's operational responsibility for managing and directing the health and human service agencies through greater supervision of each agency commissioner. As a result, the HHSC Executive Commissioner, as the governor's appointee, is authorized to employ the Commissioner of DSHS with the Governor's approval and to supervise and direct the activities of the Commissioner of DSHS. Further, HHSC has responsibility for coordinating development and submission of joint agency strategic plans and a consolidated budget. HHSC is involved in policy development for all HHS agency programs and, as such, reviews all proposed rules of all human and health agencies and has final authority to adopt rules for each HHS

agency. HHSC, as the State Medicaid Agency and CHIP Agency, is the official policy making body for the portions of those programs administered by DSHS. The increased authority and responsibility of HHSC has been instrumental in increasing coordination for planning and implementation and has helped reduce duplication and maximize resources across the heath and human service agencies. Organizational charts that include the Governor's Office, HHSC, DSHS, and the Title V program will be available upon request at the time of the Block Grant review.

There have been major changes in key agency personnel and the organizational structure since the passage of HB 2292 of the 79th Texas Legislature in 2003. Personnel changes have focused on leadership positions existing under the new Department of State Health Services structure.

- Mr. Albert Hawkins, HHSC Executive Commissioner, selected Eduardo Sanchez, M.D., as the new Commissioner for the Department of State Health Services effective January 2004. Dr. Sanchez began his tenure as Commissioner of Health in November 2001. Prior to his appointment in 2001, Dr. Sanchez was an Austin family practice physician and health authority for the Austin-Travis County Health and Human Services Department.

- In February 04, Ms. Machelle Pharr was selected as the new Chief Financial Officer for DSHS. Ms. Pharr has held a number of finance and budget positions at several Texas state agencies and came to TDH in 2002 as TDH's Chief Financial Officer.

- In May 04, Mr. Randy Fritz was selected as DSHS' Chief Operating Officer. Mr. Fritz has an extensive background in health care administration, policy and legislative experience having served as a Project Director for the S-CHIP program in California for Maximus, Inc., Texas Bureau Chief for the CHIP Program, to former Texas Commissioner of Health Archer and various legislative and/or elected roles, including the top elected role in Bastrop County, Texas.

- DSHS Commissioner Sanchez announced on June 2004 the appointment of Dave Wanser, Ph.D., as the DSHS Deputy Commissioner of Behavioral and Community Health. Dr. Wanser served as the Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA) and is chair of the statewide Drug Demand Reduction Advisory Committee. Prior to that, he spent 14 years at the Texas Department of Mental Health and Mental Retardation, where he was director of the NorthSTAR Behavioral Health Program and director of behavioral health services.

Following these appointments, DSHS aligned the common functions of the three agencies (Texas Department of Health, TCADA, and the mental health component of the Texas Department of Mental Health and Mental Retardation) into coordinated program divisions, facilitating an integrated approach to providing services and ensuring that clients can find and access needed services. These functionally focused divisions include: 1) the Division for Mental Health and Substance Abuse Services (MH/SA); 2) the Division for Family and Community Health Services (FCHS); 3) the Division for Prevention and Preparedness Services; and 4) the Division for Regulatory Services. MH/SA and FCHS Divisions report to Dr. Wanser, Deputy Commissioner for Behavioral and Community Health Services.

The Title V program is located in the DSHS Division for FCHS. Ms. Evelyn Delgado became the Assistant Commissioner for FCHS, effective July 04. Dr. Fouad Berrahou was re-selected through a competitive process as the State Title V Director effective October 2004. Dr. Berrahou served in the same capacity within the legacy TDH for about three years prior to the HB 2292 Consolidation Act. The Division for FCHS is comprised of three sections and two offices under the Assistant Commissioner for FCHS. The sections are: Sections of Community Health Services, Specialized Health Services, and Nutrition Services and the offices are: Offices of Title V & Health Resources Development, and Research & Public Health Assessment. The Division for FCHS has administrative responsibility for most of the DSHS programs and/or funding streams dedicated to women and children's health, including Title V MCH and CSHCN, Medicaid - EPSDT medical and dental, WIC, Family Planning - Titles X, XX, and XIX, and the Breast and Cervical Cancer Control program. As such, the Division is in a position to coordinate and collaborate across programs effectively. It is also

important to note that most funding sources included in the Federal-State Block Grant Partnership budget total, such as WIC, Title X family planning, SSDI, and the federal Bureau of Primary Health Care Cooperative Agreement, are administered by the Assistant Commissioner for FCHS.

Most Title V MCH and CSHCN program areas are located in the following organizational structures:

The Title V & Health Resources Development Office includes the general administration of the Block Grant, Women's Health Area (e.g., maternity and perinatal health, breastfeeding, and domestic violence), Children's and Adolescent Health Area (e.g., early childhood, adolescent mental health, teen pregnancy), the Service Delivery Initiative, and the Texas Primary Care Office (TPCO). This offers opportunities to provide a focal point for women and children's matters and policy development, and the coordination and integration of resources of Title V and TPCO (i.e., J-1 visa waiver and the Incubator FQHC Initiative) to improve access to services for low-income families in underserved areas. The Office also funds initiatives and projects across and outside the agency. The State Title V Director has the responsibility of managing the Title V & Health Resources Development Office and reports to the Assistant Commissioner for FCHS.

The Section for Specialized Health Services (SHS) is made up of two units: 1) the Purchased Health Services Unit includes CSHCN, Kidney Health Care, Anatomical Gift Educational Program, Children's Heart Outreach Program, and Hemophilia Assistance Program; and 2) the Health Screening and Case Management Unit includes Newborn Screening and Case Management, Oral Health, Texas Health Steps (formerly EPSDT), Case Management for Children and Pregnant Women, Newborn Hearing Screening, Program for Amplification of Children of Texas, School Vision and Hearing Screening, and Spinal Screening. Ms. Jann-Melton Kissel is the Director of SHS and Dr. Lesa Walker is the Title V CSHCN Director.

The Section for Community Health Services (CHS) is comprised of two units: 1) the Preventive and Primary Care Unit (PPCU) and 2) the Performance Management Unit (PMU). CHS provides oversight for contracted community health services activities for Titles V, X, XV (Breast and Cervical Cancer), XX, Primary Health Care, Indigent Health Care, Epilepsy, and Title XIX Family Planning. The PPCU is responsible for developing policies and procedures for contracted community health services activities. The PMU develops guidelines, processes, and instruments for contract management and quality assurance for CHS programs and WIC services.

The Research and Public Health Assessment (R&PHA) Office provides the MCH epidemiology support for all Title V program areas and is responsible for SSDI . Dr Linda Bultman manages the R&PHA Office.

D. OTHER MCH CAPACITY

Attachment C shows the number and types of full-time equivalent (FTE) personnel funded by the federal-state Title V program in both the DSHS Central Office in Austin, as well as Texas' 11 Health

Service Regions (HSRs). Table 1 shows a total of 213 Austin-based FTEs in FY 05. This is a significant decrease of 45 FTEs from 258 in FY 04. Table 2 shows a total of 229 FTEs similarly funded in DSHS 11 HSRs, a slight decrease as compared to 238 in FY 04. This decrease in positions did not affect any type of job classification in particular. Several factors influenced the fluctuation of FTEs funded by state and federal Title V program. One factor is a significant number of retirements, influenced by a legislatively mandated 25% one-time payment retirement bonus. Other factors include the far-reaching effort to consolidate the administrative and human services functions of Texas health and human agencies as mandated by the passage of HB 2292, 78th Legislature.

Title V program areas are primarily located in the Family and Community Health Services (FCHS) Division, which consists of two offices (Title V & Health Resources Development, and Research & Public Health Assessment) and three sections (Community Health Services, Specialized Health Services, and Nutrition Services). Although, each Title V professional staff member uses planning to some extent to influence the course of his or her daily activities and responsibilities, directors and managers of the offices and sections/units are in the best position to know what their program areas are currently facing (or will face in the future), and in turn, to make strategic decisions and policy in light of current and future effects. Directors and managers may delegate the decision-making function to selected program specialists who, on a routine basis, play the role of catalysts in or facilitators of the planning process. It is important to note that some DSHS program specialist job descriptions are similar to those of conventional planners.

On the other hand, the Research & Public Health Assessment (R&PHA) Office provides the MCH epidemiology support to the FCHS Division. The primary services include expert statistical analysis, data management and program reporting, geographical/spatial analysis, Title V performance measures, research design and consultation, epidemiological analysis and literature reviews, case finding and active surveillance via PRAMS. R&PHA is also responsible for the State Systems Development Initiative (SSDI) and coordinates a blending of activities with PRAMS to assure existing statewide surveillance.

The CSHCN Services Program has not hired parents of CSHCN to serve on staff specifically in their parental capacity. However, the program does have certain staff who happen to be parents of CSHCN. These staff members participate in the program decision-making process and some choose to offer their valuable insights and feedback to the program on an ongoing basis.

Below are summaries of the qualifications of senior level employees:

Dave Wanser, Ph.D. is the Deputy Commissioner for Behavioral and Community Health at DSHS, the consolidated department for mental health, substance abuse and physical health. Dr. Wanser's responsibilities include administration of contracted services for a wide range of mental health, substance abuse, primary and preventive care and nutrition services and oversight of the state mental health and public health facilities.

Prior to his appointment as Deputy Commissioner, he served as Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA) for three years. TCADA purchases evidence-based prevention and treatment services, and is a national leader in the use of web-based data infrastructure for behavioral health services. As TCADA Executive Director, he chaired the statewide Drug Demand Reduction Advisory Committee comprised of 19 state agencies.

During his 15-year tenure at the Texas Department of MHMR, Dr. Wanser served as the Director of Behavioral Health Services and Director of NorthSTAR Behavioral Health Program, a multi-agency capitated managed care program in north Texas. NorthSTAR was named a semi-finalist in the 2001 and 2002 Innovations in American Government competition sponsored by Harvard University.

In addition, Dr. Wanser has been a consultant to the Center for Mental Health Services Mental Health Performance Partnership Grant Program since 1994. He is first vice-president of the Board of Directors of the National Association of State Substance Abuse Directors and was previously the

chairperson of the Adult Services Division of the National Association of State Mental Health Program Directors. He has a Ph.D. in psychology from the University of Oklahoma.

Ms. Evelyn Delgado is the Assistant Commissioner of FCHS at DSHS. Ms. Delgado is responsible for programs improving the health of all Texans, focusing on communities, families, women and children through preventive and direct health services. These programs provide direct health service to over 1.5 million Texans per month.

Ms. Delgado has an extensive background in finance and management in both the private and public sectors. She has served as the Assistant Deputy Commissioner of Long Term Care Regulatory, Assistant Regional Administrator, and in other professional capacities during her career with the Texas Department of Human Services. Ms. Delgado has actively served in United Way organizations that serve families, children and the elderly.

Ms. Delgado's educational background includes a business administration degree from Trinity University in San Antonio. She is a graduate of the LBJ School of Government Governor's Executive Training program.
Fouad Berrahou, Ph.D., was named State Title V Director effective July 2002. Dr. Berrahou is the Director of the Title V and Resources Development Office and primarily responsible for coordinating the management and administration of the Texas Title V program and reports directly to the Assistant Commissioner for FCHS Division. He also oversees the Primary Care Office activities, such as the Incubator FQHC Grants Initiative, which provides financial support and technical assistance to interested local health care organizations to becoming an FQHC. Dr. Berrahou has been with the Texas Department of Health (TDH) and then DSHS for 12 years. During this time, he worked in a variety of capacities as a health planner for the former Bureau of Women and Children and Assistant to the State Title V Director within the former Associateship for Family Health.

Dr. Berrahou graduated from the "Universite' Des Sciences and Technologies" (Oran, Algeria) with a bachelor's degree in Architecture, specializing in health care facility design; he received his master degree from the College of Architecture of the University of Houston; and completed his Ph.D. in health planning at Texas A&M University in 1993.

Lesa R. Walker, M.D., M.P.H., is the Texas Title V CSHCN Director. At present, she is also Medical Director of the CSHCN Services Program and Group Manager for the CSHCN and Title V Group in the Purchased Health Services Unit of DSHS. She oversees the Title V CSHCN activities, initiatives, and systems development for Texas and is involved in policy decisions and Rule-setting for the CSHCN Services Program.

Dr. Walker has been employed at DSHS (TDH prior to September 2004) for 19 years. From December 2002 until September 2004, she served as the Medical Director/ Director of the Public Health Policy Unit of the CSHCN Division in the Bureau of Children's Health and the Texas Title V CSHCN Director. From June 2002 through November 2002 she served as the Acting Director of the Children with Special Health Care Needs (CSHCN) Division. From September 1996 until June 2002, she served as the Director of Systems Development in the CSHCN Division. From May 1994 to September 1996, she was the Director of Special Initiatives in the Children's Health Division, focusing on special initiatives pertaining to CSHCN. From October 1993 to May 1994 she was the Director of the Children's Health Division, which included the Chronically Ill and Disabled Children's Services Program (CIDC; currently the CSHCN Program) as well as EPSDT (now Texas Health Steps). From April 1993 to October 1993 she served as the Acting Bureau Chief for the CIDC Bureau. From May 1986 to April 1993 she was the Medical Director for the CIDC Bureau.

Her educational background is as follows: B.A. in Biology, 1976, from the University of Texas at Austin, Texas; M.D., 1980, from Baylor College of Medicine in Houston, Texas; M.P.H., 1982, from the University of Texas School of Public Health in Houston, Texas; Pediatric internship (Baylor College of Medicine in Houston, Texas and the Medical College of Ohio in Toledo, Ohio); Preventive Medicine/ Public Health Residency at the University of Michigan School of Public Health in Ann Arbor,

Michigan; Board Certification in General Preventive Medicine/ Public Health by the American Board of Preventive Medicine, January 31, 1989.

Ms. L. Jann Melton-Kissel, RN, MBA, serves as Director, Specialized Health Services (SHS) Section, effective September 2004. The SHS Section is comprised of two units: Purchased Health Services Unit which includes CSHCN, Kidney Health Care, Anatomical Gift Educational Program, Children's Heart Outreach Program, and Hemophilia Assistance Program; and Health Screening and Case Management Unit which includes Newborn Screening and Case Management, Oral Health, Texas Health Steps (formerly EPSDT), Case Management for Children and Pregnant Women, Newborn Hearing Screening, Program for Amplification of Children of Texas, School Vision and Hearing Screening, and Spinal Screening. As Section Director, Ms. Melton-Kissel has the responsibility for directing, planning, implementing, and evaluating health services for children in Texas. The Section continues its focus on increasing service integration, and is working to assure that systems are accessible for clients, community members, and providers.

Before coming to the former TDH, Ms. Melton-Kissel worked in a large metropolitan teaching hospital in the field of obstetrical nursing. She began employment with the former TDH in 1986, working in the Health Care Facility Regulatory Program. Over the years, Ms. Melton-Kissel has held multiple positions at TDH at the Division, Bureau, and Associateship levels gaining experience in budget and management.

Ms. Margaret Mendez serves as the Director of the Community Health Services Section, which was established in September 2004. The Section provides oversight for contracted community health services, including Breast and Cervical Cancer Control program, Family Planning programs (Titles V, X, XX and XIX), Primary Health Care, Epilepsy program, and County Indigent Health program. From 1999-2004, Ms. Mendez served as the Chief of the Bureau of Women's Health. From 1991 until 1999, Ms. Mendez served as the Director for the Breast and Cervical Cancer Control Program with TDH. She served as the director for a multi-purpose community health care center responsible for providing acute, preventive, and chronic care for all age groups in addition to providing support services for families. She held several positions as a policy analyst and health planner at TDH, a local health department, and the Governor's Office. Ms. Mendez received a bachelor's degree from the University of Texas at Austin and a Master of Public Affairs Degree from the LBJ School of Public Affairs at Austin.

E. STATE AGENCY COORDINATION

Due to its role in infrastructure building and due to the nature of services it provides and the various populations it serves, the Texas Title V program has multiple opportunities to collaborate with federal, state and community partners. On the federal level, Title V works with the Department of Health and Human Services (DHHS) Region VI Office of Women's Health (OWH) Alliance to prioritize, develop and implement women's health efforts in the region. Alliance meetings take place regularly throughout the year. Alliance members, who include women's health representatives from each of the states in the Region, have developed a five-year strategic plan to promote women's health throughout the Region, linking activities to federal and state initiatives and programs. Current activities include producing state summits on women's health, meeting with representatives from DHHS Region 1 OWH Alliance to share experiences and best practices experiences and working to develop a network of local women's health networks within Texas. Alliance meetings also serve as a format to provide members with state of the art information on health issues impacting women and on federal efforts to improve the status of women's health throughout the lifespan. The Title V Perinatal Health Coordinator serves on the Alliance for Region VI.

Another collaborative effort with HRSA resulted in the review of the Texas' Newborn Screening program. The Department of State Health Services (DSHS) partnered with the National Newborn Screening Genetics Resource Center (NNSGRC) to conduct the review, which included stakeholder

meetings in Austin, Dallas, San Antonio and Houston. NNSGRC is under contract with HRSA to provide technical assistance to states and territories. NNGRSC convened a review team of nine professionals from across the country that included physicians, follow-up staff, laboratory staff, CDC and HRSA representatives. The process involved an onsite review of the program, evaluation of program materials, interviews with program staff, discussions with stakeholders and responses to specific questions posed by the program. Texas is now in the process of reviewing the draft report and formulating recommendations for program enhancement.

Title V collaborates both with agencies under the auspices of the Health and Human Services Commission (HHSC), including the Department of Family and Protective Services; the Department of Aging and Disability Services; and the Department of Assistive and Rehabilitative Services; and with agencies outside of this area, such as the Texas Education Agency and the Texas Workforce Commission.

HHSC administers the Texas Medicaid program and Children's Health Insurance Program (CHIP). A woman is eligible for Medicaid if she meets the requirements for TANF. If a pregnant woman is at or below 185% federal poverty level, she receives Medicaid benefits until 60 days postpartum. HHSC is also responsible for CHIP, which serves children ages 0-19 from low-income families. Medicaid, CHIP and Title V are natural partners that work together effectively to meet the needs of women, children and families. Title V is considered a program of last resort, primarily designed to serve individuals who do not meet the Medicaid or CHIP eligibility requirements. Through an integrated screening process, individuals are referred to the appropriate program based on eligibility. Another link between the programs is the reimbursement rate. Title V does not participate in setting the rates, but uses them in reimbursing fee-for-service contractors.

A potential change in CHIP resulting from the 79th Texas Legislature will impact Title V. Pending approval by the federal government, CHIP coverage will expand to cover eligible children during the prenatal period. This expansion will provide prenatal care to women not eligible for Medicaid due to their immigration or financial status. If approved, a large percentage of the women currently receiving prenatal care under Title V will receive care through CHIP, freeing up Title V funds for other areas.

The Texas Health Steps (THSteps) program (federally known as EPSDT) has regionally- based state and contracted FTEs, who collaborate with many partners to promote THSteps services, activities, and benefits. The outreach and informing contractor is obligated to meet with community-based organizations, such as Early Childhood Intervention (ECI), WIC, Head Start, Independent School Districts (ISD), Migrant Coalitions and others in an effort to promote the understanding of preventive health care and the importance of services being accessed. In 2006, a renewed focus will be on coordinating efforts with the Department of Family and Protective Services (DFPS) to ensure that children who are involved in the protective services arena are also accessing needed services. Additionally, THSteps will continue to enhance outreach to Title V-funded clinics providing preventive health services.

HHSC also administers Food Stamps and TANF, Child and Adult Nutrition Programs, Nutrition Education and Training, Commodity Distribution Programs and the Family Violence Program. The Family Violence Program goal is to promote self-sufficiency, safety, and long-term independence from family violence for adult victims and their children. The strategy is to provide emergency shelter and support services to victims of family violence and their children, educate the public, and provide training and prevention support to various agencies. Title V is working to increase screening for domestic violence at its Title V-funded clinics and serves as a referral source for these services. The Title V program has been working with HHSC to develop a comprehensive plan to prevent domestic violence in Texas. In 2004, HHSC directed DSHS to present the document, "A Strategic Plan to Prevent Violence Against Women" to appropriate state agency leaders for review and to solicit recommendations regarding approval of the plan. Recommendations were received from the "Family Violence Program" at HHSC; the Department of Family and Protective Services; the Department of Aging and Disability Services; the Department of Assistive and Rehabilitative Services; and the Office of the Attorney General. The plan was approved in December 2004. DSHS and Title V program will

coordinate with each of these state agencies and with the Interpersonal Violence Prevention Collaborative in the implementation of the plan.

Title V also collaborates with the Community Resource Coordination Groups (CRCGs) of HHSC. CRCGs are community-based interagency teams comprised of public and private providers who work with family members to develop individual service plans for children and adolescents whose needs require interagency cooperation. A bill passed by the 77th Texas Legislature called for the development of a joint Memorandum of Understanding (MOU) between health and human services agencies, related state agencies and state-level partners to promote a statewide system of local-level interagency CRCGs to coordinate services for children and youth who require services from more than one agency. The MOU is reviewed and updated on a regular basis. Regional Title V social workers serve on all local CRCGs and central office staff are represented on the state advisory committee. Currently, there are approximately 150 CRCGs in Texas.

Two other partnerships that fall under HHSC are the Office of Early Childhood Coordination (OECC) and the State Early Childhood Comprehensive Systems (SECCS) Grant. The OECC is responsible for promoting community support for parents of all children younger than six years of age through an integrated state and local-level decision-making process, and for providing for the seamless delivery of health and human services to all children younger than six years of age to ensure that all children are prepared to succeed in school. Title V staff work closely with the OECC to help achieve its mission and objectives and to implement the SECCS Grant which seeks to develop a comprehensive, coordinated early childhood service system through the development of a comprehensive state plan.

Through the Federally Qualified Health (FQHC) Incubator Grants Initiative, DSHS provides funding and technical assistance to local entities interested in pursuing FQHC designation so they can develop a competitive application at the federal level. The Texas Primary Care Office (TPCO) collaborates with the Texas Association of Community Health Centers (TACHC) to provide training and TA to these entities. Both TACHC and TPCO share the common goal of growing the number of FQHCs serving the state, thereby improving access to care for low-income families in underserved areas. TPCO is under the oversight of the State Title V Director.

Title V staff have collaborated for a number of years with the federal Special Supplemental Nutrition Program for Women, Infants and Children (WIC), administered by DSHS, on breastfeeding promotion and other projects designed to enhance the health of their shared populations, such as smoking cessation and promotion of healthy nutrition and physical activity.

Under the oversight of the Title V program, the Teen Pregnancy Prevention Workgroup (TPPW) works closely with mental health and substance abuse programs and the WIC program within the agency. TPPW also coordinates with the Texas Office of the Attorney General, specifically with the "Fragile Families" Program and the "Fatherhood Initiative."

Title V staff have working relationships with the Texas Medical Association (TMA) as well as the professional organizations for pediatricians, family practice doctors, obstetrician-gynecologists, certified nurse midwives and direct entry midwives. Through these relationships, information, knowledge and resources are shared and entities work to further joint projects and common goals. Title V staff communicate regularly with TMA staff on events and activities at both organizations. TMA is represented on maternal and child workgroups at DSHS, including the PRAMS Advisory Committee and the Perinatal Depression Provider Partnership coordinated by Title V program. Title V staff also provide information for the TMA Committee on Maternal and Perinatal Health meetings. The agencies have partnered on activities, such as the development of a letter from physicians to employers regarding the benefits of supporting their employees who desire to pump breast milk during the workday in order to maintain breastfeeding.

Texas has six HRSA-funded Healthy Start projects, located in Fort Worth, Dallas, Houston, San Antonio, Brownsville and Laredo. These community-based maternal and child health programs work to reduce infant mortality, low birth weight and racial disparities in perinatal outcomes and also screen

and refer for perinatal depression. Individually, Healthy Start Projects initiate activities to promote breastfeeding, immunization, and maintaining a healthy weight. The projects have joined together to form the Texas Healthy Start Alliance (TxHSA), which provides a forum for networking, resource sharing and collaboration for the projects and serves as a link to the National Healthy Start Association. TxHSA and Title V work together on joint projects, such as the annual Texas and DHHS Region VI conferences and the perinatal depression provider partnership.

The Texas March of Dimes (MOD) funds short-term projects that seek to improve perinatal outcomes; serves as the state-level interface with the national Prematurity Campaign and seeks to connect resources, develops state-level activities, and raises awareness among state and local government and business leaders and the public regarding prematurity. The MOD's commitment to improving prenatal outcomes and reducing prematurity aligns with the goals of the Title V program. MOD is represented on various DSHS maternal and child health workgroups, such as the perinatal depression provider partnership and the PRAMS advisory committee. Title V staff serve on the MOD statewide program services committee and the Prematurity Campaign Committee. DSHS and MOD are also partnering on publications, folic acid promotion and other projects to prevent prematurity and low birth weight rates and reduce infant mortality.

Texas Perinatal Association (TPA) provides perinatal education for doctors, nurses, administrators and other personnel in the rural communities in Texas, primarily through conferences and workshops. The TPA is a critical resource for conveying information to providers about Texas Title V activities. Regional Title V staff work with TPA to produce two regional conferences a year to educate providers on issues relevant to improving perinatal outcomes in Texas.

Title V coordinates and funds adolescent health activities in conjunction with the Texas Education Agency (TEA) Regional Service Centers and the Texas Council Center through the Texas School Health Network. The network collaborates with school districts to plan and implement school health programming with the goal that all students receive a program of physical and health education, appropriate health services, and a nurturing environment. Regional School Health Specialists are stationed in each Regional Education Service Center and are contacts for DSHS programs, such as abstinence education and injury prevention. TEA regularly provides updates to statewide partners on grant funding opportunities, education policy changes, and other updates related to adolescent health. Title V also coordinates with Baylor College of Medicine, which is a recipient of the Federal Maternal Child Health Leadership in Adolescent Health Education grant. Baylor provides training and technical assistance on adolescent issues to the DSHS Texas Health Steps Program, the state program for EPSDT.

CSHSN

The creation of the Department of State Health Services (DSHS) on September 1, 2004 provides new opportunities for coordination within DSHS and with other state agencies. The newly formed DSHS includes substance abuse and mental health services as well as the programs historically associated with the legacy Texas Department of Health. Thus, the CSHCN SP will have increased opportunities to coordinate services with substance abuse and mental health services programs. Ongoing partnerships with other state and federal agencies and partners play an important role in CSHCN SP and assist in the program's ability to meet the needs of the CSHCN population. Some of these partnerships are detailed below.

CSHCN SP will continue to provide leadership in coordinating development and promotion of medical homes through the Medical Home Workgroup (MHWG) and the Medical Home Learning Collaborative (MHLC). The MHWG includes representatives from the Health and Human Services Commission (HHSC), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), and the Department of Assistive and Rehabilitative Services (DARS), as well as, family members, advocates, and private providers. The MHWG meets quarterly to report on efforts of agencies and groups and to continue work on the strategic plan to educate providers and families and promote the development of medical homes. The CSHCN SP coordinates Texas' participation in the MHLC. The HHSC State Medicaid and CHIP Director is part of the state team. The

MHLC is a HRSA funded opportunity to work with local medical practices and other states to demonstrate and learn about medical homes and their efficacy.

Collaboration with the state Medicaid program and with federal Title XIX occurs extensively through the Benefits Management Workgroup (BMW), a Medicaid and CSHCN SP policy development and coordination workgroup led by HHSC and the claims contractor for Medicaid and CSHCN SP. CSHCN SP staff participates in the leadership of the BMW. CSHCN SP collaborates with the Children's Health Insurance program and federal Title XXI by providing "wrap around" services (e.g. travel, case management, durable medical equipment, etc.) to children on CHIP who may need them.

CSHCN SP will collaborate with the Texas Department of Insurance, HHSC, the Texas Council for Developmental Disabilities and others to help increase the effectiveness of private insurance for CSHCN. Among efforts being explored by HHSC is the development of a program to empower families to negotiate with their private health insurance providers.

CSHCN SP staff serves on the HHSC Consumer Directed Services Advisory Committee which helps develop mechanisms for greater consumer direction in Medicaid state plan programs and waivers.

CSHCN SP staff serve on interagency initiatives involving many agencies working to improve the overall service delivery system for CSHCN and others. A CSHCN SP staff member is appointed by the Governor to the Early Childhood Intervention (Part C of IDEA) Advisory Committee to address the service needs of children with developmental delay from birth to age 3 and their families. A CSHCN SP staff member serves as the DSHS appointee to the Texas Council for Developmental Disabilities, an agency funded under the Developmental Disabilities Act to address systems change, capacity building, and advocacy to promote the independence, productivity, and inclusion of Texans with developmental disabilities. A CSHCN SP staff member serves on the Community Resource Coordination Groups (CRCG) interagency team. The team helped develop a revised memorandum of understanding to reflect the changed structure of the health and human services system in Texas and update the interagency effort to assist children and adults with complex needs. Regional staff continue to serve on interagency CRCGs throughout Texas. CSHCN SP staff serve on the Texas Integrated Funding Initiative, a demonstration project blending funding to more effectively and efficiently serve children with severe emotional disturbances.

CSHCN SP staff serve on interagency committees addressing specific conditions such as asthma, oral health, traumatic brain injury, and trauma and EMS. A CSHCN SP staff member is the DSHS agency representative on the Interagency Council on Autism and Pervasive Developmental Disorders, established by legislation in 1987. The Council is composed of seven family members, appointed by the governor, and representatives from five state agencies, appointed by the commissioners of the respective agencies. The Council develops a state plan that identifies and articulates the needs of individuals with autism and other PDDs, makes recommendations to state agencies providing services, and advises the Texas Legislature about legislation needed to develop and maintain quality intervention and treatment services.

CSHCN SP staff serve on the Children's Policy Council (CPC), a council of family members with many agencies represented. The CPC was established by legislation to recommend policies and practices to agency and elected leaders to improve the service delivery system for children with disabilities and special health care needs. The CPC submits an extensive status report and recommendations to the Texas Legislature every two years.

CSHCN SP leads a DSHS Transition Workgroup that is expected to become multi-agency over time. Recently proposed legislation would require DSHS to collaborate with DARS and the Texas Education Agency to develop a memorandum of understanding to coordinate efforts to assist youth with disabilities in their transition to adulthood. This legislation is not signed and its outcome depends on the results of the current Special Legislative Session.

In addition, family members of CSHCN and providers are active in state policy and systems

development through their participation in the Regional Advisory Committees for Medicaid Managed Care. Certain of these Regional Advisory Committees have formally established a subcommittee to focus on CSHCN.

The Title V CSHCN five-year needs assessment and annual planning process involved multiple stakeholders, including representatives of the health and human services and education state agencies. The needs assessments and strategic plans of the groups named above were considered and used as key indicators of stakeholder input. Through its interagency coordination efforts, the CSHCN SP has been effective in making other agencies aware of the CSHCN Title V performance measures, and, in many cases, uniting support for working toward achieving those measures.

F. HEALTH SYSTEMS CAPACITY INDICATORS

1. The rate of children hospitalized for asthma (10,000 children < 5 yrs of age)
The rate of children hospitalized for asthma (ICD-9 codes: 493.0-493.9) per 10,000 children less than five years of age.

The Healthy People 2010 objective to reduce hospitalization for asthma in children 0-5 to no more than 25 per 10,000 was not reached over the last five-year period. In Texas, the 2004 provisional annual rate of hospitalization for asthma among children less than 5 years of age is 37.3. While this number is slightly higher than the 2003 rate of 35.7, the rate had dropped in each previous year of the five-year period, from a rate of 39.0 in 2000.

The oscillation noted in Texas over the last five years is likely due to the fact that Texas is home to a diverse mix of air pollutants. The Gulf Coast region is home to one of the largest petrochemical complexes in the world. Many Texas cities have grown dramatically over the past 20 years increasing the numbers of automobiles and trucks on Texas roads. These factors coupled with the high number of days with sunshine, contribute to air pollution in most of our cities.

The overall drop from the year 2000 can be attributed to work done by the Asthma Coalition of Texas, in which the Texas Department of State Health Services plays an active part. As outlined in the original Texas Asthma Plan, one of the major goals recommended by the Texas Asthma meeting participants was to establish a statewide asthma coalition. Since the October 2000 meeting, the Texas Department of State Health Services and American Lung Association of Texas have brought together a small group of individuals from a variety of disciplines and geographic areas to form the Asthma Coalition of Texas (ACT) Steering Committee. The vision of this coalition is to optimize the health and quality of life of Texans with asthma by:

1) Informing health care providers, patients and families, the public, payers, employers, and governmental partners about:
a. The elements of evidence-based, state-of-the-art asthma care
b. The personal and societal burden that asthma imposes
c. Misconceptions and myths about asthma
d. Barriers to optimal asthma care
2) Promoting research to improve the delivery of asthma care in Texas and to delineate the role of the environment in the development and exacerbation of asthma

3) Communicating with local asthma coalitions, health care providers and provider organizations, patients and families, community based organizations, and governmental partners
4) Disseminating information about Texas asthma projects, resources for patients and providers, developments in asthma care and research, and data on the health of Texans with asthma
5) Collaborating with groups to improve indoor and outdoor air quality
6) Encouraging and supporting activities that measure the health of Texans with asthma
7) Advocating for rules, policies, and laws that advance the vision of the Asthma Coalition of Texas.

2. The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.
Several capacity indicators demonstrated significant increases during the five-year cycle illustrated in this grant application (2000-2004). HSCI #02 is related to the percent of Medicaid enrollees aged less than one year who received at least one initial periodic screen. Data indicate that there was an improvement from 75.0 % in FY 00 to 98.7% in FY 04 in this critical child health indicator. Preventive care that starts early is essential to the lifelong health of an individual and this capacity indicator bodes well for the health of Texas' children. This improvement may be attributable in part to several factors, including the enhanced efforts of the Texas version of the EPSDT program, known as Texas Health Steps, to inform caretakers of newly certified individuals on the value of preventive services. This outreach stresses the value of a medical home, the importance of preventive care, and active assistance in scheduling medical, dental and transportation services. Enhancements in the reporting of managed care encounter data also positively impacted HSC 02.

3. The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.
Data show a decrease by 48% in the number of CHIP enrollees less than one year who received at least one periodic screen, from 5,407 in 2003 to 2,823 in 2004. The total enrollment for the same period shows a similar trend, decreasing from 727,434 to 651,054. Although disenrollment from CHIP in Texas could be the result of changes in employment, income, or access to employer-sponsored insurance, there is a concern among advocates and policy analysts that the primary cause may be changes made in eligibility requirements on enrollment by the 78th Texas Legislature in 2003. These changes include: 1) decreasing the continuous coverage period from 12 months to six months; 2) increasing premiums for families above 100% of the FPL and cost-sharing for families below 185% of the FPL; 3) elimination of income deductions for items such as child care costs; and 4) implementing a 90 day waiting period for coverage.

4. The percent of women 15-44 with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
Among resident births in 2003 for women ages 15-44, the percentage with adequate or better prenatal visits was 70.4% overall. For the Medicaid population, the percentage was 70.1, and for the non-Medicaid population it was 70.5%. This percentage has increased steadily since 2000, when it was 65.4%, although it is still significantly below the target of equal to or greater than 80%.

On both the systems side and the individual side, there are several reasons why prenatal care may not be accessed at the target rate. Title V funds contractors to provide accessible, high quality, culturally competent prenatal care across Texas. However, despite this support, there are not enough health care providers to fully serve the at-risk population. Several Texas counties have no health care providers that offer these services. In other cases, providers may not be fully cognizant of the needs of the population, especially as the demographics of Texas are changing due to an influx of new populations with diverse needs. Women's health care systems may not be working in an integrated, comprehensive manner, so appropriate and timely referrals aren't made, or necessary follow up does not occur.

5. Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.
Review of several maternal and child health indicators reveals that the non-Medicaid population in Texas is doing better than the Medicaid population and better than the state as a whole. For low birth

weight, infant death and the percent of infants born to women receiving prenatal care, the 2003 Texas rates have worsened from 2002. In all three cases the non-Medicaid population is performing better than the state as a whole and better than the Medicaid population. Using the Kotelchuck Index, the percent of pregnant women with adequate prenatal care has improved slightly in Texas from 69.6% in 2002 to 70.4% in 2003. Both Medicaid and non-Medicaid populations showed improvement over 2002, with the greatest increase in the Medicaid population, from 68.5% in 2002 to 70.1% in 2003. Other than the adequacy of prenatal care, the trends seem to be worsening in Texas, especially in the Medicaid population. This is significant because of the 377,373 births in Texas in 2003, 51% were Medicaid. It appears that while the Medicaid population may be increasing the number of prenatal visits, they are still entering prenatal care later than their non-Medicaid peers and their birth outcomes are still worse. As Title V continues to explore and promote best practices to improve the health outcomes of the non-Medicaid population, sharing this information with the Texas Medicaid Program and its providers may contribute to improvement in outcomes across the state.

6. The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women.
The percents of poverty level for Medicaid eligibility vary by age group:
a. Infants (0 - <1): 185%
b. Children (1 -- 5): 133%
(6 -- 18): 100%
(19-20): 17%
c. Pregnant Women: 185%

These are the poverty levels for eligibility requirements that govern the Texas Medicaid program. Basically, these poverty levels show that the older the child gets, the lower the eligibility coverage reaches, unless she is pregnant. Due to planned changes in the federal funding for SCHIP and other budgetary concerns, the 78th Texas Legislation Regular Session in 2003 made changes to the CHIP enrollment eligibility to include the reduction of the poverty level for pregnant women from 185% to 158%. This was the first change in the poverty level for eligibility for many years. Later, in 2004, the Health and Human Services Commission re-adjusted the poverty level for eligibility to 185%.

7. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Increases have been demonstrated in several capacity indicators during the five year cycle of this grant application (2000-2004). HCSI 07 identifies the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. Based on the available annual data, this indicator has gone from a five-year low of 51.2% in 2001 to a high of 56% in 2004. This shows that an increased number of 6-9 years old children are accessing needed dental diagnostic, preventive, and therapeutic services. This improvement is attributable to several factors, including but not limited to, enhanced outreach and information, and scheduling and transportation assistance efforts provided through the Texas version of the EPSDT program, Texas Health Steps. These outreach efforts have focused on the fact that early access to preventive dental services can decrease the level of dental disease experienced by this population group and have generated an increasing number of inquiries from recipients and their caregivers about oral health.

8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.
To report accurately on this indicator, all SSI beneficiaries in Texas receive rehabilitative services through Medicaid. The State Children with Special Health Care Needs program does not serve this purpose for SSI beneficiaries in Texas. This measure is therefore not applicable.

9(A) The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.
Infant Birth and Death Certificates

Current Status: DSHS currently has the capacity to link birth and death records and perform analyses using this data for program planning and policy formulation purposes. The agency has the responsibility for vital statistic registration in Texas. Data are readily available.
Limitations: Final vital records data files are usually two years behind; not all record fields, and therefore, data variables are fully populated; methodological differences in the calculation of variables, e.g. Texas calculates weeks of gestation differently compared to NCHS standard reporting yielding discrepancies in reported prematurity rates.

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims files:
Current Status: DSHS currently has the capacity to link birth records and Medicaid data. Texas requires significant time and resources to manage and link these types of data due to 350,000 births and millions of Medicaid eligibility records and /or claims generated per year.
Limitations: Medicaid data are processed and stored at two remote contractor locations, direct access to the data is limited based on HIPAA, general confidentially and system management of risk and need. The enormity of available data and the amount of resources required to prepared and manipulate the data prohibit an increased frequency of data linking activities without considerable and prudent program prioritization and workload planning.

Annual linkage of birth certificate and WIC eligibility files:
Current Status: DSHS currently has the capacity to link birth certificate and WIC data.
WIC data are readily accessible and birth record extracts for PRAMS are linked monthly to improve contact information of potential respondents in order to increase response rates.
Limitations: Final vital record data files are usually two years behind and not all record fields, and therefore, data variables are fully populated. There is no indicator on the birth certificate of WIC participation during pregnancy and again not all record fields are fully populated in WIC.

Annual Linkage of birth certificate and newborn screening files:
Current Status: Texas Newborn Screening (NBS) program tests for five disorders (PKU, galactosemia, congenital hypothyroidism and congenital adrenal hyperplasia) which if left untreated, can cause severe mental retardation, illness or death. Texas Early Hearing Detection and Intervention (TEHDI) Program is the State's universal newborn hearing screening, tracking and intervention program. Hospitals with obstetric services and birthing facilities with 100 or more births per year located in counties with population greater than 50,000 are legislatively mandated to offer newborn hearing screening (NBHS).
Limitations: Direct access to NBHS data is available. However, newborn laboratory screening data are not readily available.

Hospital Discharge Surveys
Current Status: The Texas Health Care Information Council (THCIC) has responsibility for collecting hospital discharge data from all state licensed hospitals except those that are statutorily exempt from reporting requirements. Exempt hospitals include those located in counties with a population of less that 35,000 or counties with a population of more than 35,000 but fewer than 100 licensed hospital beds. DSHS acquired direct access to this database after September 1, 2004 when THCIC joined the agency.
Limitations: Because Hospital Discharge Data are collected using the uniform bill (UB-92) format, the data collected is administrative rather than clinical. Final data files are usually two years behind and data are available for approximately 95% of all hospital discharges. Hospital Discharge data with personal identifiers to facilitate linking cannot legally be made available; and Institutional Review Board (IRB) approval is required to obtain data elements that can serve as an identifier to link mother and child within the database. Public Data Use Files (PUDF) are available to users for a standard fee.

Annual Birth Defects Surveillance
Current Status: Texas Birth Defects Registry is a population-based registry, which collects statewide data on pregnancies affected by birth defects. The registry is based upon active surveillance of infants and fetuses with birth defects born to women residing in Texas. Texas Birth Defects Registry became statewide starting with deliveries in 1999. Records based on abstracted medical information are

matched to vital records (such as birth certificates and fetal death certificates) filed with the vital records.
Limitations: Prevalence data of selected birth defects are readily available. However, direct access to the data system requires review and approval at both the Registry and IRB levels, making data linking activities less likely to proceed without targeted resources and prudent program planning.

PRAMS
Current Status: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a Centers for Disease Control (CDC) sponsored initiative to reduce infant mortality and low birth weight. PRAMS is an on-going state specific population-based surveillance system. It is designed to identify and monitor selected maternal experiences before, during and after pregnancy. A sample of about 300 mothers is drawn every month from the birth records provided by the Bureau of Vital Statistics at DSHS. PRAMS uses mixed mail and telephone modes to conduct interviews with biological mothers of infants aged 60-180 days old. Texas initiated PRAMS data collection in May 2002, and is one of 32 states in the U.S. currently participating in the initiative. Data from PRAMS can be used for research and policy related purposes. Examples of research topics conducted with PRAMS data include prenatal care, nutrition/folic acid awareness, and alcohol and tobacco use.
Limitations: The current response rate for the mail/telephone survey is approximately 63%, below the 70% CDC requirement. Findings from the first year of data collection (2002 births) are being analyzed and will be used for internal programmatic purposes within the agency.

9(B) The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.
Youth Risk Behavior Survey
Current Status: The Youth Risk Behavior Survey (YRBS) is one component of the CDC epidemiologic surveillance system developed to monitor the prevalence of youth behaviors that influence health. DSHS has direct access to and the capacity to analyze this database.
Limitations: Survey is conducted biennially in selected metropolitan areas and only students 9th-12th grade in private and public schools are sampled. Therefore results may not be representative of non-metropolitan areas and data cannot be used for regional estimates.

Texas School Survey
Current Status: Texas Commission on Alcohol and Drug Abuse (TCADA) in collaboration with the Public Policy Research Institute at Texas A&M University conducted two statewide surveys of drug and alcohol use among students in elementary and secondary schools. Reports of these surveys are currently available for 1988 through 2002, but not direct access to the database or data files. A third survey was fielded in the 2004-2005 school year.
Limitations: Surveys are only conducted in public schools therefore private school students and dropouts are not represented in the sample. Estimates of substance use in this survey are based on self-reports.

9(C) The ability of States to determine the percent of children who are obese or overweight.
Pediatric Nutrition Surveillance Survey
Current Status: The Pediatric Nutrition Surveillance System (PedNSS) monitors the growth, anemia and breastfeeding status of low-income children across the nation who participate in federally-funded MCH and nutrition programs. Texas began submitting quarterly extracts of WIC data to CDC for PedNSS in 2004 and expects to receive reports on nutritional status and infant feeding practices in 2005. This agency also has the capacity to analyze WIC data for program planning and policy formulation purposes.
Limitations: WIC data do not contain all the data items requested by CDC e.g. length of time breastfed, and therefore some variables are calculated from existing data. Similarly, some supplementary data items requested by CDC are not available in the Texas WIC data, e.g. introduction to supplementary feeding, television viewing habits, and household smoking.

Department of Family Protective Services
Current Status: The Department of Family and Protective Services (DPFS) investigates reports of

abuse and neglect of children and adults who are elderly or have disabilities. It also provides services to children and families in their own homes; contracts with other agencies to provide clients with specialized services; places children in foster care; provides services to help youth in foster care make the transition to adulthood; and places children in adoptive homes.
Limitations: Direct access to data is not available. However ad hoc reporting can be requested. Data books and annual reports are readily available for 1995-2004 and provide descriptive statistics of the services provided by the agency by fiscal year.

Behavioral Risk Factor Surveillance Survey
Current Status: The Behavioral Risk Factor Surveillance Survey (BRFSS) is a cross-sectional telephone survey of adults age 18 or over, conducted annually by state health departments with assistance from CDC. Data are used to identify emerging health problems, establish and track health objectives, develop or evaluate disease prevention activities and support health-related legislative efforts. MCH staff has access to database.
Limitations: The survey consists of core questions asked in all states, supplemented with a choice of CDC-approved optional modules covering additional health topics. Optional modules vary from one year to the next, limiting comparisons over time. Weighted data for Texas are available by age, sex, income, or race/ethnicity groupings, but the sample is too small for multivariate analysis.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The concept of performance measures has contributed greatly to ensuring accountability, not just for Title V staff to assess the progress Texas makes from year to year, but also to compare Texas' status and progress with those of other states. At a time when budgets are constrained and resources are tight while the demand for services increases, the performance measures help to frame and focus the efforts of Title V programs and the resources that support them. Two other concepts that have helped are the pyramid of MCH service levels and outcome measures. The latter provide a long-term focus for Title V activities while national and state performance measures provide short-term focus. The link between the two types of measures means that activities designed to advance the state toward meeting short-term measures will lay the foundation and initiate progress toward achieving long-term outcome measures. The pyramid enables Title V staff to view how funds are proportioned across direct health care, enabling services, population based services and infrastructure building services to ensure that there is an appropriate balance of funds that reflect the different needs in Texas.

During the current needs assessment process, Title V partners and stakeholders identified an overwhelming number of needs related to the Title V populations. Title V staff categorized the needs according to pyramid levels. Next, staff used stakeholder input and their own knowledge and expertise to determine which of the identified needs were most significant to the Texas Title V populations. While most critical needs were aligned and reflected in the national performances measures, others were addressed through the development of state performance measures with activities linked to MCH service levels as outlined in the pyramid. Through this process, staff members are able to assess and address the critical needs of the state.

Since 2000, Texas has met two of the six national outcomes measures: the postneonatal mortality rate per 1,000 live births and the child death rate per 100,000 children aged 1-14. One, the ratio of black infant mortality to white infant mortality has remained the same. The remaining outcome measures, infant mortality, neonatal mortality and perinatal mortality, have increased. The 2004 postneonatality rate of 2.1 live births per 1,000 is an improvement from the 2000 rate of 2.3. The child death rate per 100,000 is the lowest it has been in five years, 22.8, an improvement from the 2000 rate of 24.2. The 2004 infant mortality rate of 5.8 per 1,000 live births has increased from the 2000 rate of 5.7. Similarly, at 3.7, the 2004 rate of neonatality mortality rate per 1,000 live births is higher than the 2000 rate of 3.4. At 9.2, the perinatal mortality rate per 1,000 live births plus fetal deaths is higher than the 2000 rate of 8.9.

The prevailing trend is slow progress for most of the mortality outcome measures and minimal or no progress for the outcome measures dealing with racial and ethnic disparity. This trend indicates that Texas has been more effective in developing activities that improve outcomes for older infants and children, but is still struggling to find the most effective blend of activities to improve outcomes for fetuses and neonates and to address disparities. These outcome measures reflect the health status of pregnant women and newborns and relate to the pre-pregnancy, perinatal and neonatal environments so efforts must be targeted to address these areas. Many of the activities in the FY06 plan are designed to address these trends, although activities and resources must also continue to focus on improving the progress made in the other outcome measures.

Some of the factors that impact performances and outcome measures are beyond the control of the Texas Title V program. While Title V can identify specialized facilities that care for high-risk neonates, it cannot ensure that facilities exist in all parts of the state that need them. The Title V program can work to increase awareness and assure the identification and referral of victims of domestic violence, but it does not have the capacity to prevent it or treat the victims.

The five-year needs assessment clearly shows that the Title V populations in Texas continue to have unmet needs linked to the MCH service levels, and the performance and outcome measures. Texas Title V will continue to use these tools to develop the FY06 and future activity plans to ensure the greatest success in improving outcomes for Texas families.

B. STATE PRIORITIES

Title V is concerned about the health and well being of all Texas residents. As shown in the needs assessment section, indicators show improvement in many areas of the health of Texas' population. Others, however, show discouragingly little progress. As part of Texas' effort to improve health status and eliminate health disparities within the entire Title V population, Title V staff members include the following priority focus areas, highlighting priority needs for this reporting period. The priority focus areas are organized by population group and service levels of the pyramid.

I. Women and Infants

Infrastructure Building
Reduction of domestic violence
Title V stakeholders identified domestic violence as a priority need for women and infants in the 2005 needs assessment. Reducing the incidence of domestic violence has been a priority need in Texas for Title V since being added as a state priority in 2002. The need has been well documented. In 2002, researchers conducted the first surveys of sexual assault and domestic violence prevalence in Texas, providing critical state-level data that documented the need (Busch et al., A Health Survey of Texans, 2001; and Texas Council on Family Violence, Prevalence, Perceptions, and Awareness of Domestic Violence in Texas, 2003.) The survey, which focused on sexual assault, found that nearly two million Texans have been sexually assaulted at some time in their lives and that nearly one in ten Texas girls were assaulted before they reached age 14. The domestic violence study reports the problem as an epidemic in Texas, with 47 percent of all Texans having been abused in their lifetimes. Both studies confirm that these forms of violence are underreported. The Healthy People 2010 goal for intimate partner violence is to reduce it to 3.6 physical assaults per 1,000 persons aged 12 years and older. Texas does not maintain statistics in a manner consistent with HP 2010, but available data would indicate that currently, the rate in Texas is much higher.

In Texas as elsewhere, gaps in rigorous research, data collection and evaluation make effective prevention efforts for domestic violence difficult to define or implement. In order to build infrastructure, state agencies are working collaboratively with service providers, research institutes and advocates to create shared methods of tracking relevant data. DSHS Title V staff have taken a lead in coordinating the collaborative efforts to promote engagement of local communities across the state in violence prevention through active local coalitions and by serving as a resource for local and regional staff in building successful coalitions. Texas stakeholders want to know what works to end sexual assault and domestic violence in their communities so that they may utilize limited resources effectively.

Population-Based
Reduction of obesity among women (new need)
Obesity has been discussed for several years as one of the major public health issues facing the country. Texas data parallel a national trend of increased overweight and obesity. The state is not immune to this problem with overweight rates as high as 39.1% and obesity rates as high as 33.6% for women of childbearing age in some parts of Texas (BRFSS, 2003). These rates have steadily increased over the years and projections predict a continued trend. Healthy People 2010 goals for weight status include increasing the proportion of adults who are at a healthy weight to 60% and reducing the proportion of adults who are obese to 15%. Healthy weight is defined as having a body mass index of more than 18.5 but less than 25. Clearly the rate of overweight and obesity among Texas women is higher than the national target. The problem is exacerbated by the fact that no one solution exists to address the problems of overweight and obesity, although poor nutrition and decreased physical activity are linked. Trends in overweight and obesity are a reflection of the rapid changes society has undergone, including the increase of labor saving devices, the ready availability of a multitude of inexpensive, processed foods and the constant demands on time that many family members face. These same factors have led to decreased physical activity. Additionally, mental health issues such as low self-esteem, depression and emotional trauma can contribute to overweight and obesity. While recent research does not strongly support whether overweight and obesity will

replace smoking as the leading cause of morbidity and mortality, it is clear that they are associated with diabetes, cardiovascular disease, mobility problems and reduced quality of life. It is also clear the learned habitual behaviors of adult family members around poor nutrition and decreased physical activity often lead to the development of the same behaviors in the children. Research indicates that the earlier in life a child faces overweight and/or obesity, the more challenging it will be to obtain and maintain a healthy weight later in life and the earlier the child may face some of the concomitant physical problems.

Additionally, certain data show a link between obesity during pregnancy and the incidence of neural tube defects, some of which can be fatal or can severely compromise the child. There is also some data that indicates that when the mother is obese, there is higher risk of prematurity, delivery complications and cesarean delivery, all of which can potentially lead to increased perinatal, infant, neonatal, postneonatal and child mortality. Since the incidence of obesity is high among African American women, it may play a role in the infant death disparity.

Although reducing adult obesity is a new priority for Texas, early research is showing that multi-factor interventions can have a positive impact on the rate of overweight and obesity. (William H. Dietz, M.D., Ph.D., CDC's Role in Combating the Obesity Epidemic, Statement before the Senate Committee on Health, Education, Labor and Pensions, May 21, 2002.) While much remains unknown about the impact of overweight and obesity on perinatal outcomes, what is known confirms that being at a healthy weight going into pregnancy increases the likelihood of a less complicated pregnancy and delivery.

Reduction of fetal and maternal exposure to smoking, alcohol and other substances (new need)
A number of stakeholders responding to the Title V Needs Assessment Survey identified reducing fetal exposure to tobacco, alcohol and illegal drugs as a top priority. However, Texas does not have a reliable mechanism in place for measuring alcohol consumption and illegal drug use during pregnancy. Furthermore, because Fetal Alcohol Spectrum Disorder (FASD) is often not screened for or diagnosed at birth or even in the first year of life, it is difficult to get an accurate assessment of the incidence. Consequently, the focus will be to reduce fetal exposure to tobacco.

At 17.6%, the smoking rate among women of childbearing age is lower than the national average (20.3), but considerably higher than the Healthy People 2010 target rate of 12%. In some parts of the state, such as Central Texas (Health Service Region 7), the overall smoking rate is as high as 24.3%. Incidence of smoking is highest among the White population (23.7) and lowest in the Hispanic population (18.7). It is also highest among individuals ages 18-29. Because of the addictive qualities of nicotine, quitting smoking can be very challenging. Women may be particularly reluctant to discontinue smoking due to fears of weight gain. Also, because smoking is considered a stress reducer, individuals may be reluctant to seek healthier alternatives.

Research indicates that smoking increases numerous risks to mothers and infants, including cancer and cardiovascular risks to the mother, and prematurity, low birth weight, SIDS, asthma and cancer risks to the child, which can lead to increased perinatal, infant, neonatal, postneonatal and child mortality. Decreasing or discontinuing smoking can yield immediate health benefits that increase over time. While nicotine is known to be addictive research has shown that in many cases, women will decrease or discontinue smoking during pregnancy simply at the request of a health care provider (Boschert, Sherry. Use 'five A's' in smoking cessation counseling: brief interventions make big difference - Clinical Rounds, OB/GYN News, Jan. 15, 2005). Quitlines, especially when used in a proactive manner, such as Quitline staff contacting a consenting individual, are also considered efficient and effective (Tobacco Use Cessation: The Effectiveness of Quit Lines, National Conference of State Legislators, http://www.ncsl.org/programs/health/tobaccostop.htm.)

II. Children and Adolescents

Population-Based

Reduction of obesity among children
Obesity is linked to decreased physical activity, diabetes, cardiovascular disease, joint pain, mobility problems, and other long-term health complications. Texas mirrors the national trend of increased overweight and obesity in children. In 2003, the national average was 13.5% while Texas was slightly higher at 13.9%, both increasing from approximately 10% in 1999. The highest incidence in Texas children ages 1-4 is among Hispanics, which continues to be a rapidly growing population within Texas. Preventing obesity is a priority objective for the Governor of Texas and the DSHS Commissioner. After reviewing both perceived and actual needs, Title V subject matter experts and stakeholders identified obesity as a critical issue and thus selected it as a state priority need. While many evidenced-based interventions exist to curb obesity among children, it is strongly believed that teaching parents of very young children healthy nutritional habits can positively impact children through adulthood and minimize the number of chronic diseases associated with overweight and obesity. Thus, the desired outcome of the reduction of obesity is intended to decrease the child death rate per 100,000 children aged 1-14.

Infrastructure Building
Increase access to dental care (new need)
Lack of access to dental care results in untreated dental caries and other oral health problems. Possible negative health outcomes may include chronic mouth pain, disrupted eating patterns, weight loss, and loss of school and work time for families (economic damages). Dental caries are 5-7 times more common than reported respiratory disease among 5-17 year-old youth. While many factors contribute to dental caries, in 2004, studies show, nationally, children living in poverty have four times more dental caries then those families with income levels above the federal poverty level. Texas ranks 44th among the U.S. with the greatest percentage of children in living in poverty. Even those qualifying for government-assisted care may not receive services. In 2003, only 47% of children age 1-14 who were Texas Health Steps eligible received oral health screens. Access to dental providers and services is especially a problem among those who live along the Texas/Mexico boarder or in rural areas. After reviewing both perceived and actual needs, the Title V subject matter experts and stakeholders identified access to dental care as a critical issue and thus selected it as a state priority need. Dental caries and/or tooth decay is the most common childhood chronic disease and is largely preventable. Left untreated, tooth decay can lead to abscesses and infections, pain, dysfunction and weight loss. In an effort to decrease the child death rate per 100,000 in children aged 1-14, access and timeliness of access to services can equate to healthier outcomes.

Improve and expand healthcare infrastructure (new need)
Early and periodic screening results in fewer adverse health outcomes. In 2004, 52% of Texas counties were designated as Health Professional Shortage Areas. As a result, less than 60% of children eligible for Texas Health Steps were screened in 2003. Twenty-one percent of Texas children live in poverty, as compared to a 16% US average and 22% of Texas children are without health insurance as compared to 12% nationally. Research has shown that access to alternative sources of health information is vital in creating a thriving population. After reviewing both perceived and actual needs, the Title V subject matter experts and stakeholders identified increasing the healthcare infrastructure as a state priority need. By establishing links between childcare health and/or medical consultants and the early care and education community, information and resources on child health and safety can be provided as well as parent education, family support, social emotional development, and medical home information. The intent is to develop a system to provide families and communities the necessary support and information to make healthy decisions regarding their families. The intended outcome is to decrease the child death rate per 100,000 children aged 1-14 within the state of Texas.

III. CSHCN

CSHCN SP considers all six of the national and state performance measures for which it is responsible to be priorities as confirmed by the needs assessment. However, for the list of ten Title V state priorities (which include consideration of the priority needs of women, infants, children, and adolescents, the CSHCN SP prioritized the following four state priority needs:

1) Increase partnerships with families of CSHCN in decision-making at all levels and family satisfaction with the services they receive (NPM 2) (Enabling and Infrastructure-Building Services)
2) Increase the number of CSHCN who receive coordinated, ongoing, comprehensive care within a medical home (NPM 3) (Enabling and Infrastructure-Building Services)
3) Improve the organization and coordination of community-based service systems for CSHCN and their families so that an increased number of families of CSHCN report that these systems are easy to use (NPM 5) (Enabling and Infrastructure-Building Services)
4) Increase the number of youth with special health care needs who receive the services necessary to make transition to all aspects of adult life (NPM 6) (Enabling and Infrastructure-Building Services)

The four selected state priorities (NPM 2, 3, 5, and 6) reflect the current capacity and focus of Title V activities and influence. Due to the interconnectedness of all the Title V CSHCN performance measures, the activities in these areas incorporate activities to achieve NPM 4 and SPM 1 as well. Specific activities for all national performance measures and the one state-added performance measure are planned in FY06.

Please see the Needs Assessment, Section II.B.5, Selection of Priority Needs (CSHCN-specific narrative) and Form 14 for additional information.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	95	95	95	95	95
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	338	343	401	426	383
Denominator	338	343	401	426	383
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Unduplicated screening data are not available for 2002 for all conditions mandated by the State-sponsored Newborn Screening Program. Therefore, this measure cannot be completed as defined for this submission.

Notes - 2003

Demoninator is occurrent births for State Fiscal Year 2003: September 2002 - August 2003.

Notes - 2004

Demoninator is occurrent births for State Fiscal Year 2004: September 2003 - August 2004.

a. Last Year's Accomplishments

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers who submit unsatisfactory specimens and provide them with educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory (NBS) Quality Assurance Officer will provide monthly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.

Update: In FY04, DSHS NBS Laboratory received a total of 368,768 initial specimens. A total of 4,373 or 1.18% received were unsatisfactory for testing. Technical assistance contacts were made to 271 providers. The increase in the number of contacts from FY03 is at least partly attributable to the Dec., 2003 NBS newsletter that included an order form for materials and a toll-free number. During FY04, approximately 22,898 sets of educational materials, primarily targeting at providers, were distributed. Materials included specimen collection guides posters and CDs, practitioner guides, and weight conversion charts. In conjunction with the DSHS Texas Health Steps lab staff, six in-services on specimen collection were presented. In March, 2004, NBS staff, in collaboration with the National Laboratory Training Network, presented three NBS Symposia. NBS staff continued the annual provision of NBS specimen collection and screening materials to 345 schools of nursing/phlebotomy.

Activity 2: Educate parents and health professionals about newborn screening benefit and state requirements by distributing brochures on newborn screening to health care providers, placing information regarding newborn screening on the newborn screening website, and making an email address available for any questions regarding newborn screening.

Update: The NBS website remains a viable tool in educating parents and professionals on the legal requirements and benefits of screening for genetic disorders. In FY04, a total of 384,937 web site visits occurred. Additionally, over 159,421 sets of educational materials on NBS issues targeting parents and health professionals were distributed. The NBS Program continued the Maternal Phenylketonuria (PKU) Project. This project involves contacting the parents of all 15-year-old females who were diagnosed with PKU to alert them to the required treatment during pregnancy and of the potential adverse consequences to the infant for not following the special diet. During the first 2 quarters of FY 04, NBS mailed 33 packets of information and provided 100 copies of the MPKU educational materials listed above.

Performance Assessment: During FY04, NBS exceeded the 95% annual objective with 100% follow-up and case management of identified presumptive positives through increased awareness of the legal requirements for newborn screening and continued technical assistance to minimize the number of unsatisfactory tests submitted.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reduce the number of unsatisfactory specimens by identifying providers who submit unsatisfactory specimens and provide them with educational materials on specimen collection and handling procedures.			X	
2. Educate parents and health professionals about newborn screening (NBS) benefit and state requirements by distributing brochures to health care providers, placing information on the NBS website, and providing an			X	

email address for questions.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory Quality Assurance Officer will provide monthly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.

Update: Through February, 2005, the DSHS Newborn Screening (NBS) Laboratory received a total of 189,450 initial specimens. A total of 1,224 or 0.64% of the total received were unsatisfactory for testing. Technical assistance contacts were made to 129 providers. Approximately 9,320 packets of educational materials, primarily targeting providers, were distributed to hospitals, clinics, laboratories, and midwives, including specimen collection guides and posters, CDs, newsletters, practitioner guides and weight conversion charts. The Texas Newborn Screening Program provided materials for in-service training on specimen collection for Ben Taub Hospital in Houston, Endocrine Nursing Seminar in Dallas, and for the Seton Clinical Assistance Lab in Austin. In collaboration with the state laboratory EPSDT program, specimen collection training was provided in Marble Falls, Waco, Bastrop, and Bryan. The Program distributed 282 videos on Indicators for a Genetic Referral to Texas obstetricians and gynecologists.

Activity 2: Educate parents and health professionals about newborn screening benefit and state requirements by: distributing brochures on newborn screening to health care providers, placing information regarding newborn screening on the newborn screening website, and making an email address available for any questions regarding newborn screening.

Update: The Newborn Screening Program (NBS) distributed 57,370 brochures and 130 posters for parent education about the purpose and importance of newborn screening. The NBS web site had 10,948 visits. NBS created a new sickle cell brochure entitled Parents' Alert: Your newborn has been identified with probable Sickle Cell Disease. The brochure provides a brief explanation of sickle cell disease and includes telephone and fax numbers for the six Texas Sickle Cell Association Chapters.

c. Plan for the Coming Year

Activity 1: Reduce the number of unsatisfactory specimens by identifying providers (hospitals, laboratories, clinics) who submit unsatisfactory specimens in order to provide them educational materials on specimen collection and handling procedures. The Newborn Screening Laboratory Quality Assurance Officer will provide monthly unsatisfactory specimen collection reports to the Case Management Program and assist in developing training and educational materials.
Output Measure (s): Percent of total newborn screens that are unsatisfactory; number of providers identified as submitting unsatisfactory specimens; number of contacts made with providers identified as submitting unsatisfactory specimens; number and type of educational

materials distributed.
Monitoring: Monthly review of percent increase/decrease in unsatisfactory specimens.

Activity 2: Educate parents and health professionals about newborn screening benefit and state requirements by distributing brochures on newborn screening to health care providers, placing information regarding newborn screening on the newborn screening website, and making an email address available for any questions regarding newborn screening.
Output Measure(s): Type and number of materials distributed and website hits.
Monitoring: Ensure distribution of materials and document interactions with stakeholders.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		57	57	57.1	57.2
Annual Indicator		57.0	57.0	57.0	57.0
Numerator		142384	142384	142384	142384
Denominator		249840	249840	249840	249840
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.3	57.4	57.5	57.6	57.7

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking.

Update: A legislated consolidation of health and human services agencies resulted in the elimination of many advisory committees, including the statewide CSHCN Advisory Committee,

which has been an important source of stakeholder input. The CSHCN Services Program (SP) enhanced other methods to document family and stakeholder concerns and recommendations, including improved documentation of family participation at local and statewide meetings attended by program or contractor staff. Staff and contractors reported 103 meetings in which 386 consumers participated. Topics included the HB 2292 reorganization of health and human service agencies, Medicaid and CHIP changes, medical care in foster homes, mental health benefits, access to services, community assessment, respite care, transition, permanency planning, and the CSHCN SP waiting list. Parents, especially those of children on the waiting list, expressed frustration with the CSHCN SP 6-month reapplication requirement. Frustration waned, however, as the waiting list decreased significantly.

Activity 2: Require and confirm that all service contractors have quality assurance (QA) plans and provide technical assistance and training to service contractors so that by FY 05 all the quality assurance plans include ways to measure progress toward the Title V CSHCN national performance measure of family partnership and satisfaction.

Update: CSHCN SP contractors were required to assess family participation and satisfaction through reviews of quarterly reports and ongoing discussions. Staff provided technical assistance and conducted on-site evaluations to update FY05 contractor requirements and reporting. Family surveys consistently report high levels of satisfaction. Staff conducted four conference calls with contractors to discuss the Title V Performance Measures and to promote revision of QA plans. By the end of 2004, all contractors had revised QA plans. Nearly 90% of case management contractors reported ongoing QA activities, with most submitting revised QA plans that reflected the Title V performance measures. Staff continued to provide training and technical assistance to contractors regarding family partnership and satisfaction. The Family-to-Family Partnership and 75% of the Wellness Center contractors also reported completion of family satisfaction surveys.

Performance Assessment: In FY02, the national CSHCN Survey reported that 57% families of CSHCN aged 0-18 who partner in decision making at all levels responded that they were satisfied with the services they receive. Changes in this measure cannot be ascertained until it, or a similar survey, is repeated. CSHCN SP documented family partnering in decision-making, and client/family surveys consistently reported high levels of satisfaction with the program service contractors.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking.				X
2. Require and confirm that all service contractors have quality assurance plans and provide technical assistance and training to service contractors to assure that QA plans include ways to measure progress of family partnership and satisfaction.				X
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Activity 1: Continue formal and informal mechanisms for partnering in decision making with families of CSHCN and promoting family networking through forums that include, among others, committees and councils having CSHCN family representatives, focus groups, ad hoc groups/task forces, input from case management contacts/activities, etc.

Update: The CSHCN SP continued to refine methods to obtain and document family and other stakeholder input. These methods included improved documentation of stakeholder meetings by CSHCN SP program and contractor staff.

By the end of the 2nd quarter, 420 consumers had participated in 53 meetings on topics such as: consolidation of health and human services agencies; Medicaid managed care; waiting lists; SSI; mental health; prescription drugs; advocacy development for families; and moving children to families from institutions. Seven program contractors reported that they worked with parent advisory groups.

A needs assessment for CSHCN was drafted. Texas-specific data, reports and recommendations from stakeholders were used to identify major issues impacting the health and well-being of CSHCN and their families. The program petitioned over 350 stakeholders, including parents and other advocates, to prioritize issues and make recommendations. Thirty-nine respondents identified priority needs and made recommendations contributing to the Title V CSHCN needs assessment and planning process.
The Title V CSHCN Director supported the successful application of Texas Parent to Parent (TP2P) for the Champions for Progress Incentive Award funded through a MCHB grant to the Early Intervention Research Institute at Utah State University. The funds enable TP2P to provide technical and networking assistance to parent support groups to enhance family partnerships and collaboration in Texas.

The CSHCN SP submitted a grant application to HRSA to enhance community-based family networking and partnerships with primary care practices providing medical homes for CSHCN. The grant was approved but not funded.

Activity 2: Require and confirm that all service contractors have quality assurance (QA) plans and provide technical assistance and training to service contractors so that all QA plans include ways to measure progress toward the Title V CSHCN national performance measure of family partnership and satisfaction.
Update: All program service contractors had the required QA and evaluation plans and routinely assessed family participation and satisfaction. CSHCN staff reviewed quarterly reports and, through ongoing discussions and on-site evaluations, assessed progress in this area. Technical assistance was provided.

A competitive request for proposal (RFP) was issued for not-for-profit organizations that serve CSHCN and their families. The RFP required responders to say how they would meet one or more CSHCN Title V performance measures. Proposals were required to include involvement of families and assessing family satisfaction.

c. Plan for the Coming Year

Activity 1: Support and develop formal and informal mechanisms for partnering in decision-

making with families of CSHCN and promoting family networking.
Output Measure(s): Identification of CSHCN/family listservs with which the program has had informative interaction and describe membership and CSHCN/ family participation; identification of key CSHCN stakeholder groups with significant CSHCN/family membership (including contractor advisory groups) with which the program has partnered/interacted and describe membership and CSHCN/family participation; number and types of questions and issues raised and/or information shared via listservs and/or meetings of stakeholder groups and key input obtained; program discussion/response with regard to stakeholder/family input.
Monitoring: Routine collection and analysis of listserv interfaces and stakeholder meeting reports; documentation of program discussions and use of consumer input in decision-making.

Activity 2: Systematic reporting of consumer satisfaction with CSHCN Services Program contractor services and with the state service systems in general.
Output Measure(s): Level of satisfaction with CSHCN Services Program contractor services and with state service system; recommendations/ input from consumers and program/contractor response to consumer feedback.
Monitoring: Review of quarterly reports from CSHCN Services Program contractors.

Activity 3: Develop a plan to assess consumer satisfaction with CSHCN Services Program health care benefits and with the state service systems in general.
Output Measure(s): Consumer satisfaction plan completed.
Monitoring: Documentation of the steps taken to develop a plan for assessment of consumer satisfaction.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		58.3	58.3	58.4	58.5
Annual Indicator		58.3	58.3	58.3	58.3
Numerator		399631	399631	399631	399631
Denominator		685206	685206	685206	685206
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	58.6	58.7	58.8	58.9	59

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Inform CSHCN providers and families of the principles and practice of providing/obtaining and utilizing a medical home through participation in the Texas Medical Home Training Conference and dissemination of materials in the CSHCN SP provider bulletin, family newsletter, and website.

Update: Regional and central office leadership and staff attended the American Academy of Pediatrics sponsored Texas Medical Home Training Conference, "Every Child Deserves a Medical Home" in Houston, TX. Staff helped plan the conference attended by 145 people, including physicians, allied health care professionals, and family members.

A Medical Home Workgroup (MHWG) was convened with membership drawn from the conference participants and related programs, including the Healthy Child Care Texas Grant and the State Early Childhood Coordination Planning Grant. The MHWG met monthly and developed its vision and mission as initial steps in creating a strategic plan.

Articles on medical home were published in the February and August issues of the Provider Bulletin (circulation 3,400), and in all quarterly issues of the Family Newsletter (circulation 4,900). Staff developed a medical home fact sheet for distribution at provider workshops. A medical home web page was added to the CSHCN SP website and includes the fact sheet. A draft brochure was developed and will be finalized and adopted by the MHWG in the next fiscal year.

Activity 2: Document case management efforts to connect CSHCN with medical homes.

Update: Regional staff provides case management services that include linking CSHCN with medical homes and reporting the number of contacts made with CSHCN, their families, and health care providers. Staff also has drafted a policy that contains a definition of medical home and specifies that regional staff will, as part of individualized case management services, link children to medical homes.

CSHCN SP case management and direct service contractors link children with medical homes. Each contractor has its own policies and procedures regarding assessment of medical home and referral needs. Program staff monitored contractor compliance through quarterly performance reports and on-site reviews of policies and procedures.

Regional case management staff made 9,496 contacts with families and providers to link children to and foster development of medical homes. Of the 3,366 children on contractor case management programs, reports indicated that 3,197, or 95%, were served by a medical home.

Performance Assessment: In FY02, the national CSHCN Survey report that 58.3% of CSHCN aged 0-18 received coordinated, ongoing, comprehensive care within a medical home. Changes in this measure cannot be ascertained until it, or a similar survey, is repeated. The Medical Home Conference and the ongoing work of the MHWG helped clarify and spread information about the medical home. Information from contractors and case management staff demonstrate effort to link CSHCN to medical homes.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Inform CSCHN providers and families of the practice of providing/obtaining a medical home through participation in Texas Medical Home Training Conference and dissemination of materials in the CSHCN SP provider bulletin, newsletter and website.			X	
2. Document case management efforts to connect CSHCN with medical homes.		X		
3.				
4.				
5.				
6.				
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8.				
9.				
10.				

b. Current Activities

Activity 1: Inform CSHCN medical providers and families of the principles and practice of providing/obtaining and using a medical home through the TDH-organized Medical Home Work Group and through dissemination of materials, including articles and references, of best practices and education/training opportunities on this topic in the CSHCN Program's provider bulletin, family newsletter, and via the CSHCN website.

Update: Program staff directed and supported the work of the Medical Home Workgroup (MHWG). The MHWG met monthly and had active participation of physicians, advocates and family members, community-based organizations, and state agency staff. The group finalized the MHWG Strategic Plan, which will be a part of the Texas Early Childhood Coordination grant strategic plan and contribute to the CSHCN Title V annual plan. The MHWG completed a Medical Home Brochure that presents information for families and providers in a concise single sheet format. The Brochure, in English and Spanish, was added to the medical home page of the CSHCN SP web site for distribution to the public.

The CSHCN SP was selected to participate in the 2nd Medical Home Learning Collaborative sponsored by MCHB and organized by the National Initiative for Children's Healthcare Quality (NICHQ). The Texas contingent in the Collaborative included program staff, a Texas Pediatric Society representative, a family representative, a Medicaid agency representative, and three pediatric practice teams. The practice teams provide geographic and practice-type diversity. Participants held multiple conference calls and participated in the Collaborative Learning Session. Practice teams completed assessments using the Medical Home Index.

The Title V CSHCN Director supported the Texas Parent to Parent successful application for a Champions for Progress Incentive Award. Funds will be used to support a parent conference focused on medical home issues in July 2005. Articles on medical home were published in the October CSHCN Family Newsletter (circulation 4,900) and November CSHCN Provider Bulletin (circulation 3,400). DSHS regional CSHCN case management staff attended the statewide Primary Care Conference in Houston and distributed literature on the CSHCN SP and medical home to over 200 primary care providers.

Activity 2: Document case management efforts by TDH staff and contractors to connect

CSHCN with medical homes.

Update: Regional staff and case management contractors provided case management services including linking CSHCN with medical homes. Program staff monitors these efforts through review of quarterly performance reports and on-site review of contractor's policies and procedures.

Regional case management staff made 9,496 contacts with families and providers to link children with and to support development of medical homes. Of the 3,336 children on contractors' case management programs, contractors reported that 3,202 or 96% were served by a medical home.

c. Plan for the Coming Year

Activity 1: Engage in Medical Home Learning Collaborative (MHLC) with three medical practices to learn about, demonstrate, and spread medical homes in Texas.
Output Measure(s): Reports from the MHLC; reports on "spread" medical home efforts and results.
Monitoring: Track reports and activities of the MHLC, including spread efforts and results; review of quarterly reports.

Activity 2: Collaborate with others to develop and disseminate a family medical home tool kit through websites, mailings, conference exhibits, and other means to assist families in expanding the medical home services available from their primary care physicians.
Output Measure(s): Family medical home tool kit developed; dissemination efforts and numbers distributed and to whom.
Monitoring: Track progress on development of family medical home tool kit; review quarterly updates on dissemination.

Activity 3: Provide leadership to, and collaborate with members of the Medical Home Workgroup (MHWG) to increase awareness and knowledge of medical homes among all relevant audiences.
Output Measure(s): Progress reports on the MHWG strategic plan; provider Bulletin and Family Newsletter articles published (report number and content and circulation); number and type of presentations conducted at conferences, seminars, and other venues; website (postings to CSHCN Services Program website; Texas page of AAP medical home website).
Monitoring: Review of quarterly progress reports on implementation of the Medical Home Workgroup strategic plan and outreach efforts.

Activity 4: CSHCN Services Program regional staff and contractors work to help CSHCN link to and develop medical homes.
Output Measure(s): Number and percent of CSHCN Services Program case management clients of regional staff and contractors who have a primary care physician; number of CSHCN linked to primary care physician by CSHCN Services Program case management staff/contractors.
Monitoring: Review of quarterly reports on CSHCN Services Program clients of regional staff and contractors with a primary care physician.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18*

whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		52.9	52.9	52.9	52.9
Annual Indicator		52.9	52.9	52.9	52.9
Numerator		366173	366173	366173	366173
Denominator		692198	692198	692198	692198
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52.9	52.9	52.9	52.9	52.9

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS. This measure was held constant from 2002 to 2007.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.

Update: Seventy-eight clients received insurance premium assistance paid by the CSHCN SP. Of these, 60% were between the ages of 1 and 14.

Activity 2: Document provision of health care benefits to those eligible for CSHCN services. Update: In FY04, 1,907 clients received health care benefits through the CSHCN SP. Of these, 65% resided in the Dallas metro area, the Houston metro area, or in South Texas. 67% were between 1 and 14 years of age.

Activity 3: Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.

Update: Preliminary data show that, at the end FY04, 395 clients were on the CSHCN SP waiting list, 204 of which have no other significant coverage for health care benefits. In FY04, 1,344 clients were moved from the waiting list to active health care benefits.

Performance Assessment: In FY02, the national CSHCN Survey report that 52.9% of families

of CSHCN aged 0-18 reported that they have adequate private and/or public insurance to pay for services they need. Changes in this measure cannot be ascertained until it, or a similar survey, is repeated. National reports show decreases in health coverage for children in Texas. Changes in Texas Medicaid and CHIP eligibility and procedures have resulted in fewer children being served by these programs than would have been expected in the absence of these changes. In FY04, the CSHCN SP provided health care benefits to more CSHCN than in FY03 and 1,344 clients were moved from the waiting list to receive health care benefits.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.		X		
2. Document provision of health care benefits to those eligible for CSHCN services.	X			
3. Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Document payment of insurance premiums for clients on the CSHCN Program to help families maintain private insurance.

Update: Preliminary data showed that 57 clients statewide received insurance premium assistance paid by the CSHCN SP. Of the clients receiving these benefits, 47% were from the Dallas, Houston or South Texas metro areas, and 61% were between the ages of 1 and 14.

Activity 2: Document provision of health care benefits to those eligible for CSHCN services.

Update: Preliminary data showed that 1,495 clients received CSHCN SP health care benefits. Of the clients receiving benefits, 65% were from the Dallas metro area, Houston metro area or South Texas, and 64% were between the ages of 1 and 14.

Activity 3: Document the number of CSHCN on the waiting list by age and region who have no other source of insurance.

Update: - Preliminary data showed that a total of 827clients were on the CSHCN SP health care benefits waiting list, 457 of whom had no other third party coverage for health care benefits. Of those on the waiting list with no other coverage, 74% resided in the Dallas, Houston or South Texas metropolitan areas, and 70% were between the ages of one and 14.

c. Plan for the Coming Year

Activity 1: Pursue opportunities with employers, private sector insurance providers, and the Texas Department of Insurance to enhance benefits for families of CSHCN.
Output Measure(s): Number and type of meetings with relevant stakeholders; number and types of opportunities explored; documentation of any actions taken and family feedback obtained.
Monitoring: Review of quarterly reports from key staff; document minutes with relevant stakeholders and follow up on opportunities explored.

Activity 2: Provide information on public and private health insurance to families of CSHCN through the CSHCN program website, newsletter articles and other means.
Output Measure(s): Number of articles published in Family Newsletter; information on CSHCN Services Program website; number and type of informational materials shared via staff, contractors, or other means.
Monitoring: Review of quarterly reports on informational shared and track progress on posting information on the website.

Activity 3: Expand the number of providers serving CSHCN Services Program health care benefits clients.
Output Measure(s): Number and type of new providers by type and location.
Monitoring: Review of monthly reports from Texas Medicaid and Healthcare Partnership.

Activity 4: Payment of insurance premiums and drug co-pays for clients on the CSHCN Services Program to help families maintain cost effective private insurance.
Output Measure(s): Number of CSHCN Services Program clients receiving Insurance Premium Payment Assistance (IPPA); number of CSHCN Services Program clients receiving drug co-pay assistance; all new CSHCN Services Program clients informed of IPPA and drug co-pay assistance.
Monitoring: Review of quarterly reports.

Activity 5: Provide CSHCN Services Program health care benefits to eligible children.
Output Measure(s): Number of ongoing CSHCN Services Program health care benefits clients in different population categories by age; number of CSHCN Services Program health care benefits clients in different population categories by age for whom the CSHCN Services Program provides health care benefits.
Monitoring: Review of quarterly reports.

Activity 6: Monitor CSHCN health care benefits clients on the waiting list.
Output Measure(s): Number of CSHCN Services Program health care benefits clients on the waiting list by age; number of CSHCN Services Program health care benefits clients on the waiting list who have no other source of insurance by age; number of CSHCN Services Program health care benefits clients removed from the waiting list by age.
Monitoring: Review of quarterly reports.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective		76.8	76.8	76.9	77
Annual Indicator		76.8	76.8	76.8	76.8
Numerator		193670	193670	193670	193670
Denominator		252253	252253	252253	252253
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77.1	77.2	77.3	77.4	77.5

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. A conservative 1% increase forms the basis of established targets from 2003 to 2007.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Activity 1: Continue to fund contracts to support community-based service systems' infrastructure organization and coordination.

Update: In FY04, the CSHCN SP funded 14 case management and community/family resource services contractors. By the end of FY04, contractors served 9,499 families and had attended over 1,100 local/community meetings focusing on the needs of CSHCN. These meetings provide opportunities to share information, improving local service systems, and better coordinate services. Contractors also participated in hearings related to upcoming changes in the state health and human services agencies in order to voice concerns about effects on local service systems.

Activity 2: Continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll free information and referral line, as well as the CSHCN Program website.

Update: In FY04, the information and referral line received 11,040 calls. These calls resulted in 14,701 referrals to contractors and/or other programs or services. The CSHCN SP website received an estimated 65,572 hits. A review of contacts to the website and calls to the referral line indicated that the majority were concerned with how to obtain services (not exclusively CSHCN SP services). No discernible trend in positive or negative feedback was identified.

Activity 3: Continue participation in state-level advisory groups, task forces, committees and similar forums that are working on issues pertaining to CSHCN.

Update: Central office and regional CSHCN SP staff attended and reported on 103 meetings covering issues pertaining to CSHCN. CSHCN SP contractors reported on 12 state level meetings they attended. Cumulatively, 2,846 stakeholders attended these meetings; 386 were

parents, families, or CSHCN. Other stakeholders participating in meetings included 855 service providers, 722 agency staff, 340 from other groups or individuals, and 363 individuals who could not be classified. The meetings covered diverse topics including: the impacts of HB 2292; systems of care assessment; transition issues; permanency planning; community assessment; and cost share programs. CSHCN SP staff assisted the Children's Policy Council, the Texas Integrated Funding Initiative, and other interagency groups, in incorporating Title V principles as they developed program and policy recommendations to state leaders. Staff met throughout the year to evaluate the input received at these meetings and to discuss the program impact and response.

Performance Assessment: In FY02, the national CSHCN Survey report that 76.8% of families of CSHCN aged 0-18 reported that community-based services are organized so they can use them easily. Changes in this measure cannot be ascertained until it, or a similar survey, is repeated. Participation by staff in systems changes arenas and extensive involvement of case management staff are undertaken to help improve the community-based services system.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund contracts to support community-based service systems' infrastructure organization and coordination.				X
2. Continue to publicize and gather/monitor public input and feedback on the program and service delivery via the toll-free information and referral line, as well as the CSHCN Program website.				X
3. Continue participation in state-level advisory groups, task forces, committees, and similar forums that are working on issues pertaining to CSHCN.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Fund contracts to support community-based service systems' infrastructure organization and coordination.

Update: In FY 05, the CSHCN SP funds 14 case management and community/family resource services contractors to support community-based service systems infrastructure organization and infrastructure. The program funds 10 service contractors (wellness centers, medically fragile children, etc.) that provide and enhance client access to community-based services.

Activity 2: Supply critical program-specific and community service information and gather and review public input and feedback on the program and service delivery systems via the toll free telephone line and number of hits on the CSHCN SP website.

Update: In the 1st quarter of FY05, the CSHCN website received 11,988 hits. The information and referral line received 2,439 calls and made 3,083 referrals, an increase over previous quarters. The majority of contacts to the web site and calls to the referral line concerned how to obtain services (not exclusively CSHCN SP services). No discernible trend in positive or negative feedback was identified. Recent server problems prevented the collection of web information in the second quarter.

Note: The Family Health Services Information and Referral Hotline was discontinued as of November 16, 2004. Future reporting will be based on the new 211 information lines established by the Health and Human Services consolidation. Meetings with 211 staff were held to ensure continuity of data reporting. In the 2nd quarter FY05, Texas 211 received 18,719 MCH related calls. Due to software limits, it is not possible to determine which calls were CSHCN related. However, 72 calls have a high probability of CSHCN involvement including: 9 for pediatric neurology; 20 for child foster care, and 43 for children's respite care. Reporting capability is expected to improve over time.

The CSHCN Services Program maintains a 1-800 number to offer information to clients served by the program.

Activity 3: Participate in state-level advisory groups, task forces, committees and similar forums that are working on issues pertaining to CSHCN.

Update 2nd quarter: CSHCN SP central office and regional staff attended and reported on 53 meetings that addressed issues pertaining to CSHCN. Attendance included 1,201 stakeholders, of whom 420 were parents, families or CSHCN. Other stakeholders included 465 service providers, 614 agency staff, 153 representing other groups or individuals, and 345 individuals who could not be classified. The meetings addressed issues about Medicaid managed care; eligibility services/functions; expanding consumer directed services; waiting lists; SSI; and keeping children in their homes. CSHCN SP staff served on the Children's Policy Council and the Texas Integrated Funding Initiative, incorporating Title V principles in program and policy recommendations to state leaders. CSHCN Service Program staff met to evaluate the input received at these meetings.

c. Plan for the Coming Year

Activity 1: Participate in DSHS collaboration with Texas Information and Referral / 2-1-1 system to foster effective linking of CSHCN and their families to community services and supports.
Output Measure(s): Reports from Texas Information and Referral /2-1-1 system on utilization by CSHCN and their families; reports on improvements to Texas Information and Referral/2-1-1 system to facilitate greater levels of detail in reporting.
Monitoring: Review of quarterly reports on Information and Referral / 2-1-1.

Activity 2: Participate in interagency and intra-agency efforts to assess and improve state policies and programs that impact CSHCN and their families.
Output Measure(s): Identify relevant groups in which CSHCN Services Program staff actively participate; review recommendations impacting CSHCN; review policy and program changes impacting CSHCN.
Monitoring: Review stakeholder meeting records.

Activity 3: Expand use of appropriate languages and cultural approaches in publications and in interactions with CSHCN Services Program consumers.
Output Measure(s): Number and type of bilingual publications; expansion of Spanish language content on CSHCN Services Program website; number of training/discussions with contractors about experiences and lessons learned (informal and formal) with regard to cultural competency; number of focus groups held with families of CSHCN regarding cultural issues

and health care delivery with documentation of family attendance/input and program/contractor response.
Monitoring: Document records of communications products and initiatives by staff.

Activity 4: Provide CSHCN case management through CSHCN Services Program.
Output Measure(s): Number of CSHCN receiving case management from CSHCN Services Program contractors; number of CSHCN receiving case management from CSHCN Services Program regional staff.
Monitoring: Review of quarterly CSHCN Services Program staff and contractor case management reports.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure. Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 & 2003 indicator is the national average except for Maine which has its State value noted.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.
Since Texas does not have state-specific data or projections at this time, the 2001 and 2002 national average data should be inserted, if needed, for the 2003-2009 projections."

a. Last Year's Accomplishments

Activity 1: Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.

Update: In November, 2003, CSHCN SP staff participated in LEAH's annual transition conference, "Chronic Illness: How to Transition from Child-oriented to Adult-oriented Care." Feedback from the meeting helped program staff identify concerns that providers have regarding a question on the program Physician Assessment Form. CSHCN SP staff participated on the LEAH Advisory Committee to plan the 2004 annual conference on transition issues. Staff helped identify presenters on the economics of transition from pediatric to adult services.

Activity 2: Provide articles and references on best practices and education/training tools on transition for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletin, CSHCN website, and as possible through mail outs with various partners (e.g. advocacy groups, professional organizations, CHIP/Medicaid providers, etc.).

Update: The CSHCN SP published articles on transition issues in the Family Newsletter (circulation 4,900) and the Provider Bulletin (circulation 3,400). Articles in the Provider Bulletin included, "The Importance of Self-Determination" and "Transition Part 1 -- What is Transition and Why Is It Important?" and articles on Title V performance measures and deinstitutionalization were published in the Family Newsletter. Program staff convened a Transition Workgroup to assist with development of transition resources, and one of the planned projects was creating a training module on transition; however, due to staff changes, the work group activity temporarily was suspended toward the end of the year. A web page on transition issues was added to the CSHCN website.

Performance Assessment: National survey data is not available. Work is ongoing to improve the effectiveness of case management support of transition from pediatric to adult health care service systems and to participate in state-level meetings addressing transition to adult health care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilties, activities and outcomes.				X
2. Provide articles and references on best practices and education/training tools on transition for CSHCN for families and/or providers via Family Newsletter, Provider Bulletins, CSHCN website and as possible through mail outs with various partners.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Participate in the Leadership Education in Adolescent Health (LEAH) Advisory Board and document CSHCN staff roles, responsibilities, activities and outcomes.

Update: CSHCN Program staff participated in the LEAH program's annual transition conference, "Chronic Illness: Transitioning from Pediatric-based to Adult-based Care." CSHCN staff recommended presenters on the economics of transition from pediatric to adult services and helped promote the conference to DSHS staff and contract providers. The conference was well attended, with over 180 registrants - three times as many as previous years. More than 60 DSHS social work staff and contract providers participated. The CSHCN Program staff will continue to collaborate with LEAH program at Baylor College of Medicine by participating in the LEAH Board and annual conference planning.

The Title V CSHCN Director provided information and support to Dr. Al Hergenroeder (Principal Investigator for the LEAH program) for a multi-state collaborative HRSA grant application to help enhance education of state leaders and providers regarding the need for transition planning and services for CSHCN and their families.

Activity 2: Provide articles and references on best practices and education/training tools on transition for CSHCN for families of and/or providers via the Family Newsletter, Provider Bulletin, CSHCN website, and as possible through mail outs with various partners (e.g. advocacy groups, professional organizations, CHIP/Medicaid providers, etc.).

Update: An article entitled, "Transition Programs for Teens" appeared in the October, 2004, CSHCN Family Newsletter, and an article entitled, "Transition: AAP Web Updates" appeared in the November, 2004, CSHCN Provider Bulletin. Both of these publications are available through the CSHCN web site. A new link was added to the website Transition page to include a transition resource notebook and transition timelines in English, Spanish, Vietnamese, Chinese, and Russian through the Washington State Adolescent Health Transition Project.

c. Plan for the Coming Year

Activity 1: Provide transition planning and referrals to CSHCN SP clients through CSHCN SP case management services provided by regional staff and contractors.
Output Measure(s): Number and type of training/materials/resources provided to CSHCN SP Regional staff/contractors regarding transition of CSHCN; standardized transition/permanency planning letters for CSHCN SP health care benefits and SSI clients in the 16th and 20th years adopted.
Monitoring: Review of quarterly regional staff case management reports.

Activity 2: Work with selected CSHCN SP contractors to provide transition services to CSHCN and to report on best and promising practices (contingent on contract selection, funding decisions).
Output Measure(s): Number of selected contractors; contract performance measures; summary reports on best practices utilized.
Monitoring: Review of quarterly contractor reports and staff summaries.

Activity 3: Develop a mentoring initiative through which adults with special health care needs mentor transitioning youth with special health care needs.
Output Measure(s): Concept paper on the mentoring initiative completed; number of adult mentors recruited to participate in planning process.
Monitoring: Review of progress reports.

Activity 4: Lead DSHS Transition Workgroup to advise the CSHCN SP and help achieve Title V CSHCN objectives for transition to adult health care services, including dissemination of information to CSHCN, families, providers, and other stakeholders. Composition of the

Transition Workgroup includes youth and adults who have had special health care needs since childhood.
Output Measure(s): Number of Transition Workgroup meetings; progress reports completed; list of information on transition shared via publication/presentations.
Monitoring: Review of meeting minutes and progress reports.

Activity 5: Collaborate with other state agencies, the Texas Leadership Education in Adolescent Health (LEAH), and other transition programs by serving on boards, helping plan transition content of conferences, and sharing information on transition planning and promising practices.
Output Measure(s): Number and type of state agency, LEAH and other meetings attended; reports on input/collaborative efforts resulting from meetings and partnerships.
Monitoring: Review of meeting minutes and stakeholder meeting records.

Activity 6: Participate in the update and adoption by rule of a Memorandum of Understanding (MOU) among state agencies, including at least, the Texas Education Agency, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services and the Department of State Health Services, regarding transition services for students enrolled in special education programs (depending on legislative action in 2005).
Output Measure(s): MOU completed and signed.
Monitoring: Documentation of meetings and other collaboration on development of the Transition MOU.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	77	78	80	80	80
Annual Indicator	68.5	73.7	70.9	77.2	72.1
Numerator	331520	362212	358701	406746	380938
Denominator	483972	491468	505925	526873	528585
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

a. Last Year's Accomplishments

Activity 1: As a Healthy Child Care America grantee, develop a plan with the DSHS Immunization Division to promote timely, age-appropriate immunizations through the use of IMMTRAC (Texas Immunization Registry) system by child care centers.

Update: As a result of the DSHS Business Improvement Plan, the Immunization Improvement Action Plan, recommendations from numerous internal and external stakeholders, and the 78th Legislative Session, a partnership initiative was formed for the purpose of strengthening collaborative efforts to raise vaccine coverage levels across Texas. Prior to the reorganization of DSHS, the former Immunization Division partnered with health organizations, schools, medical societies, other formal immunization coalitions, and faith and community based organizations to raise awareness of the importance of vaccines. These relationships continue today with a focused determination to follow the best practice model followed nationally in utilizing a comprehensive, coherent, strategic approach. The state immunization system is complex and requires collaboration among many public sector, private sector, and community groups.

The Texas Immunization Stakeholder Working Group (TISWG) was formed in August, 2004, and consists of both public and private entities, government, medical, community, and parent groups. The charge is to recommend specific activities for the Immunization Branch to implement in order to increase immunization rates of both children and adults in Texas. The 16-member core group has been meeting since August, 2004. Subject matter experts and a committee structure are utilized in bi-monthly meetings to address specific topics and issues. The recommendations of the TISWG will provide input to the Immunization Branch's annual report and strategic plan.

Performance assessment: Final data for FY03 Texas immunization percentages of 19-35 month olds receiving a full array of age-appropriate immunizations was 77.1%, an increase from 70.9% in FY02. While the state target is 80%, the projection for FY04 shows 72.1%, a decrease from FY03. This is still presenting a challenge to Texas and DSHS leadership is committed to have every child immunized. Continued activities include but are not limited to statewide distribution of vaccines, well checks provided through Title V contractors, provision of training and technical assistance on immunization requirements and procedures, and the development and support of partnerships that can educate providers and promote adherence to immunization schedules in local areas. Additionally, DSHS leaders and the legislature continue to focus on age-appropriate immunizations as a top public health priority with a five-point plan for improvement.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. As a Healthy Child Care America grantee, develop a plan with the DSHS Immunization Division to promote timely, age-appropriate immunizations through the use of IMMTRAC (Texas Immunization Registry) system by child care centers.				X
2.				
3.				
4.				
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b. Current Activities

Activity 1: Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.

Update: The Texas Immunization Stakeholder Working Group (TISWG), a selected primary membership of 16 internal DSHS staff, other public and private professionals, and parents, was formed in August, 2004. The charge was to recommend specific activities for the Immunization Branch to implement in order to increase immunization rates of both children and adults in Texas. Members consist of representatives from health organizations such as Texas Medical Association, Texas Pediatric Society, Texas Pharmacy Association, Health and Human Services Commission, Parents Requesting Open Vaccine Education (PROVE), and the Texas Parent Teacher Association. The TISWG will provide a forum for diverse partners in the state immunization system to share ideas, perspectives, best practices, and resources to more effectively target efforts to raise vaccine coverage levels in Texas. The working group will determine roles and responsibilities, timelines, deliverables, and steps to implement working group activities. The objectives are to provide support for activities to raise vaccine coverage levels, to help increase awareness of the importance of early childhood vaccination, and to work with DSHS to identify and implement improvements to the state immunization system. Two follow-up meetings have occurred since the group's inception in August, 2004. New subject matter experts and partners have been added to the working group at each meeting.

The Services and Data Coordination Group of the DSHS Disease Prevention and Intervention Section will conduct a survey to collect partnership data from the Health Services Regions. The Health Services (HSR) Immunization Partnership Activity Survey has been developed and approved for distribution. Analysis of the information will be reflected in a later report. Existing immunization coalitions around the state will be included in the survey to capture and track partnership activities and best practices known to raise vaccine coverage rates.

c. Plan for the Coming Year

Activity 1; Identify and develop partnerships with internal and external stakeholders to increase collaborative efforts to raise vaccine coverage levels.
Output Measure: Number and types of partnerships; summary report on efforts undertaken.
Monitoring: Track the number and type of partnership activities.

Activity 2: Through provider and birth registrar education, training and technical assistance, promote the use of the state immunization registry, Imm Trac.
Output Measure: Percent of children under six who participate in the state immunization registry, Imm Trac
Monitoring: Track number of new children entered into the ImmTrac system. Annually, compute the total percentage based on population estimates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	50	50	50	50	50
Annual Indicator	41.6	38.9	38.9	37.0	39.3
Numerator	19631	18683	18722	18271	19258
Denominator	472252	480073	481349	493945	490212
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	37	37	37	37	37

a. Last Year's Accomplishments

Activity 1: Develop and provide via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.

Update: DSHS staff maintained both a provider and a public web-site for teen pregnancy prevention (TPP) data, best practices, and information on cost, outcomes, and social consequences of teen pregnancy. In FY04, a Teen Pregnancy and Birth Fact sheet was added to the site in preparation for national TPP month. Since January, 2004, there were 3,040 hits to the public page and 45 hits to the provider page. The spring, 2004, issue of Texas Talk was dedicated entirely to the topic of teen pregnancy. In the fourth quarter, eleven new regional teen pregnancy fact sheets containing county level data were posted to the website.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: The Abstinence Education Program served 279,928 unduplicated clients in FY04. Approximately 82% of clients served were 10-17 years of age. Other demographic estimates include 30% African American, 50% Hispanic, and 46% male and 54% female. The program has a total of 42 contractors distributed across the 10 public health regions, with a concentration of services in regions with dense population.

Activity 3: Provide funding to Title V contractors for population-based activities and family planning services to reduce and prevent pregnancy among adolescents and teenagers.

Update: Currently Texas has 60 contractors providing family planning services funded statewide by Title V. All conduct teen pregnancy prevention activities.

Activity 4: Funding awarded to Title XX contractors for family planning activities statewide to reduce and prevent pregnancy among adolescents and teenagers.

Update: Currently, Texas has 50 contractors providing family planning services funded by Title XX. All conduct teen pregnancy prevention activities.

Performance assessment: Texas birth rates for teens aged 15-17 have steadily declined over the past decade to 37 in FY03, although the projected FY04 rate is 39.3. Efforts to reduce teen pregnancy will continue to utilize a comprehensive, community-based approach including

abstinence education and family planning services. DSHS has also coordinated the Teen Pregnancy Prevention Workgroup since 2000 to foster collaboration and to promote the diffusion of best-practice models for teen pregnancy prevention. In FY06, the Title V program will solicit applications for funding through a competitive process to address teen pregnancy pregnancy in targeted areas with the highest occurrence of teen pregnancy and repeat teen pregnancy.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and provide, via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.			X	
2. Provide funding to community-based organizations to promote abstinence from sexual activites through strategies that include abstinence education, mentoring, counseling and adult supervised activities.				X
3. Provide funding to Title V contractors for population-based activities and family planning services to reduce and prevent pregnancy among adolescents and teenagers.				X
4. Funding awarded to Title XX contractors for family planning activities statewide to reduce and prevent pregnancy among adolescents and teenagers.				X
5.				
6.				
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8.				
9.				
10.				

b. Current Activities

Activity 1: Develop and provide via the Internet, resource materials to raise public awareness of teen pregnancy in Texas, including teen pregnancy rates among Hispanic and African American female teenagers less than 17 years.

Update: No materials were posted to the website in the first quarter. The Teen Pregnancy Fact Sheet for FY2002 was posted to the website in the second quarter. From September, 2004 to May 2, 2005, there were 6,548 hits to the Teen Pregnancy Prevention Page website.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.

Update: The Abstinence Education Program served 196,462 unduplicated clients in the first two quarters of FY05. The priority population is defined as the group most likely to have impact on federal, state and local performance measures, such as reduction of teen pregnancy and STDs and increased parental involvement. Approximately 77% of clients served were 10-17 years of age and 85% were ages 10-19. Other demographics include 54% females, 45%

males, 16% African American, and 47% Hispanic. The program has a total of 38 contractors located across the DSHS public health regions.

Activity 3: Provide funding to Title V contractors for population-based activities and family planning services and to Title XX contractors for family planning activities to reduce and prevent pregnancy among adolescents and teenagers.

Update: For FY05, there are 59 Title V-funded contractors, 43 Title X-funded contractors and 20 Title XX-funded contractors that provide family planning services. All of these contractors are also involved in teen pregnancy prevention activities.

c. Plan for the Coming Year

Activity 1: Make available funds through competitive RFPs for the provision of family planning services statewide.
Output Measures: Number of Title V contractors, number of Title X contractors, the number of Title XX contractors, the number of teens receiving family planning services (FPS); annual numbers of births averted.
Monitoring: Review contractor reports quarterly for number of clients served, review annual report of numbers of births averted by region.

Activity 2: Provide funding for community-based abstinence projects for adolescents and teenagers.
Output Measures: Number of youth, adults, parents and professionals participating in abstinence projects; number of contractors providing services by region.
Monitoring: Review DSHS contractor reports on the number and type of services delivered on a quarterly basis; determine if numbers of youth, adults, parents and professionals have increased.

Activity 3: Identify target areas and subpopulations in the state with highest rates of teen pregnancy and repeat teen pregnancies and provide funds through a population based competitive RFP to address teen pregnancy in the targeted areas.
Output Measures: Number of target areas of the state with highest rates of teen pregnancy; number of contracts awarded; summary report on project implementation and milestones.
Monitoring: Review work plans quarterly, review summary reports of project implementation and milestones quarterly.

Activity 4: Provide information to increase awareness of teen pregnancy rates of health disparity in Hispanic and African American teens.
Output Measures: Number and type of materials provided.
Monitoring: Review of health indicator and outcome data and best practices research.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	18	19	20	21	22
Annual Indicator	21.6	21.7	37.5	43.4	54.3
Numerator	610	596	2687	1550	6468
Denominator	2828	2749	7156	3572	11902
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	35	35	35	35

Notes - 2003

Source:
TDH, Statewide Dental Survey, 1997-2002
TDH, Oral Health Program Annual Report FY 2003.

The data used for this measure represent sealants present on any molar versus sealants placed on at least one permanent molar teeth.

Notes - 2004

Despite the FY04 annual indicator, the program has opted to set the target of 35% to reflect the limitation of this measure. The population involved is limited to the reduced/free lunch program.

a. Last Year's Accomplishments

Activity 1: Continue providing dental sealants to Texas' 3rd grade population.

Update: In FY 04, regional-based dental staff has provided dental sealants to 6,468 third graders statewide. Data specific to permanent molar teeth are not collected.

Performance assessment: Since FY02, Texas has had a steady increase in the percentage of third-graders who qualify for screening and receive sealants. Third-grade children in the free and reduced lunch program qualify for screening. There was in increase from 43.4% in FY03 to 54.3% in FY04 for children who received sealants. In addition, higher numbers of children were screened during FY04 than any previous years due to the efforts provided by regional oral health teams.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue providing dental sealants to Texas' 3rd grade population.	**X**			
2.				
3.				
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b. Current Activities

Activity 1: Continue providing dental sealants to Texas' 3rd grade population.

Update: Through the 2nd quarter of FY05, 3,046 of the 3rd grade children screened in targeted schools received dental sealants. This number amounts to approximately 35% of the 3rd graders screened in targeted schools where at least 50% of students are on the free or reduced lunch program.

c. Plan for the Coming Year

Activity 1: Continue providing dental sealants to Texas third grade population statewide.
Output Measure(s): Number of third graders who receive dental sealants.
Monitoring: Track progress of the data collection and analysis.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5
Annual Indicator	5.8	5.3	5.6	5.4	5.6
Numerator	264	247	259	259	263
Denominator	4579234	4628121	4647317	4752653	4728000
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5

Notes - 2003

Source:
1999-2002 Deaths: TDH, BVS

a. Last Year's Accomplishments

Activity 1: Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.

Update: For the grant year ending Sept. 2004, Safe Riders conducted a total of 72

presentations to adults and children regarding child passenger safety and safety seats. Of this number, a total of 26 were presented directly to children and the remaining 46 were presented to parents, mom's clubs and other pertinent groups, such as law enforcement officers. These presentations help increase knowledge of the importance of using child safety seats correctly.

Activity 2: Provide high-quality safety seats and education concerning their use to low income families through a distribution program. Seats will be provided for children from birth to about age 8.

Update: In FY04, Safe Riders provided a total of 11,398 seats to 94 local programs throughout Texas and Safe Riders provided training for each program. Subsequently, the local programs conducted child passenger safety classes and provided safety seats free-of-charge for low-income families. Seats are for children from birth to age 8. Between 125 to 175 local safety seat distribution classes were taught each month in Texas through this program. Safe Riders monitored the progress of the distribution programs, including conducting site visits to some programs. A statewide child restraint usage study is conducted during the summer each year by the Texas Transportation Institute. The most recent studies show an increase in child safety seat usage in Texas from 71.7% in 2002 to 73.3% in 2003. The 2003 safety seat usage rate is the highest rate ever recorded in Texas to date.

Performance assessment: In FY04, there were 263 reported deaths among children aged 14 years and younger caused by motor vehicle crashes, a fatality rate of 5.6 per 100,000 children, slightly higher than the 5.5 per 100,000 objective. Texas will continue efforts that should positively impact this measure. Those measures include providing education and child safety seats throughout the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.			X	
2. Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Provide child passenger safety presentations to children ages 0-8 regarding car seat safety.

Update: From September, 2004, through February, 2005, the Safe Riders Traffic Safety Program provided a total of 23 child passenger safety (CPS) presentations to a total of 812

persons throughout the state. The presentations included information about seat belts and child safety seats. Of these presentations, 15 were conducted to 409 adults, including law-enforcement officers, CPS professionals, parents, English as a Second Language students, and teen parents. The remaining presentations were made to a total of 403 children. The children's presentations included information regarding the importance of buckling up, the consequences of not buckling up, air bag dangers and information regarding pedestrian safety around school buses. An interactive game, based on the Jeopardy game, tested the students' knowledge in a fun way.

Activity 2: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.

Update: No safety seats were distributed in the first six months (September, 2004, through February, 2005). Safety Seats for this fiscal year will be distributed during May -- June, 2005. One distribution program training class was conducted during the first quarter of 2005. The application for the distribution and education program was reviewed and revised and was posted on the program website during December, 2004. The distribution and education program application was open for one month and closed on January 14, 2005. The goal was to identify 100 or more community agencies to serve as local program partners with Safe Riders. Applications for participation as distribution centers were received and scored. A total of 79 local programs were selected, covering most areas of the state and multiple sites in major urban areas. Selected agencies will provide at least two CPS classes per month to low-income families and provide the families with new child safety seats. Training schedules are being determined so that every local program will have at least two staff persons trained prior to receiving seats. Program training will take place during Spring 2005 and delivery of seats will take place during Summer 2005. Last year's program provided over 11,000 seats to local programs, which continue to offer classes and seats throughout Texas.

c. Plan for the Coming Year

Activity 1: Conduct statewide presentations and education on traffic safety.
Output Measure(s): Number of presentations conducted statewide; number of children/adults attending each presentation and the number of educational materials distributed.
Monitoring: Track progress of presentations (per calendar) as relayed in monthly report.

Activity 2: Conduct statewide safety seat distribution to low-income families.
Output Measure(s): Number of organizations or agencies that participate in the distribution and training program and the number of safety seats issued to the community program participants.
Monitoring: Review of quarterly reports which provide the number of seats distributed and the number of people trained.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	75	80	80	80	80
Annual Indicator	67.8	69.4	67.3	70.0	73.6
Numerator	249517	256959	249972	263117	282085
Denominator	368019	370258	371429	375898	383268
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75

a. Last Year's Accomplishments

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.

Update: In FY 04, 67.3% of WIC mothers were breastfeeding at hospital discharge. As of September, 2004, 64% of all WIC infants were breastfed at some point during infancy and approximately 47% of infants whose mothers were participants in the program during pregnancy initiated breastfeeding at or before the time of the infant's certification of eligibility. In the 2003 National Immunization Survey, conducted by the Centers for Disease Control and Prevention, Texas data showed that 72% of all babies were breastfed, 42% were exclusively breastfed at three months, 12% were exclusively breastfed at six months, 34% were still receiving some breast milk at six months, and 17% were receiving some breast milk at one year.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American families.

Update: In FY04, there were 250 WIC peer counselors. Peer Counselor Train-the-Trainer training sessions continued. In June, 2004, 20 train-the-trainers attended the training sessions. The Texas Breastfeeding Initiative Website remained a valuable resource for promoting breastfeeding. A total of 47,128 hits were recorded.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.
Update: In FY 04, 38 letters encouraging hospitals to apply for accreditation were sent. As a result, 12 hospitals applied and 10 new hospitals and/or birthing centers became accredited. Technical assistance and training was available by phone, email, and fax. A Frequently Asked Questions document was developed and placed on the website. In FY04, 35 Ten Step designated hospitals received a letter and questionnaire about participation in the program. In response, a total of 22 hospitals indicated the intent to follow the Ten Step Hospital Program.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: During FY 04, a total of 2,389 participants attended 84 training sessions focused on breastfeeding and lactation management and peer-counselor training program. Participants

included diverse ethnicities and professions.

Performance assessment: FY04 provisional data indicate that the percentage of women breastfeeding at hospital discharge was 73.6%, an increase from the 70% reported in FY03. Title V and WIC programs continued to support breastfeeding through health provider training, a toll-free Lactation Hotline, a website and programs at workplace and hospital settings.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.				X
2. Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among AA families.			X	
3. Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Initiative.				X
4. Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monitor breastfeeding rates of mothers using available data from Ross Labs, WIC, and PRAMS.

Update: While there is currently not a mechanism for assessing the breastfeeding rate at hospital discharge in Texas, the Title V program considers several different data sources to gain an understanding of breastfeeding initiation rates for the state. First is the "Born to WIC Infants ever Breastfed," which for October 2004 was 64.2%. This measure represents the percent of infants whose mothers were participants in the program during pregnancy and initiated breastfeeding at or before the time of the infant's certification of eligibility. Also considered is the "Born to WIC Infants Breastfed at Certification," which was 47.5% for October, 2004. While Ross Labs 2002 Mother's Survey showed 67.3% of WIC mothers breastfeeding at hospital discharge in Texas, according to WIC data, 64.7% of WIC mothers were breastfeeding at hospital discharge. The 2003 National Immunization Survey, Centers for Disease Control and Prevention, indicated that for Texas, 72% of all babies were ever breastfed, 34% were breastfed at six months and 17% were breastfed at 12 months. The Survey also indicated that the rate of exclusive breastfeeding at three months was 42% and the rate of exclusive breastfeeding at six months was 12%.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues such as maintaining the breastfeeding website and

funding community breastfeeding education initiatives, particularly among African American families.

Update: The total number of WIC participants of train-the-trainer peer counseling was 15. Four were Anglo, one was Hispanic, three were Asian/Pacific Islander and seven were of unknown ethnicity. There were no non-WIC participants for the training. The total number of hits to the Breastfeeding Website through January, 2005, was 32,571.

Activity 3: Encourage Texas hospitals and birthing centers to become accredited through the Texas Ten Steps and Baby Friendly Hospital Initiative.

Update: In the first two quarters, two packets were sent to hospitals requesting accreditation and one new hospital was accredited.

Activity 4: Provide breastfeeding training and resources to physicians and other health care professionals by using multiple methods, including distribution of educational materials and conducting training programs.

Update: A total of 44 training sessions were held for health professionals. Training sessions included Mini Basics of Breastfeeding - Parts 1 and 2, Principles of Lactation Management, Lactation Counseling and Problem Solving, Clinical Assessment of Lactation Research and Policies, and Peer Counselor Train-the-Trainer. There has been some initial discussion about developing a physician-training program for September, 2006, but no action has been taken to date.

c. Plan for the Coming Year

Activity 1: Monitor breastfeeding rates of mothers using data from WIC and PRAMS.
Output Measure: Percent of mothers who are breastfeeding at hospital discharge.
Monitoring: Review quarterly WIC data on breastfeeding initiation and PRAMS data as available.

Activity 2: Improve community access to education and support resources to promote breastfeeding by providing multiple venues, such as maintaining the breastfeeding website and funding community breastfeeding education initiatives, particularly among African American (AA) families.
Output Measure: Number of WIC breastfeeding peer counselors; number of WIC and non-WIC participants attending the training; number of hits to website; number of media spots targeting the AA population; number of AA Breastfeeding Promotion materials distributed; number of Community Action Kits distributed.
Monitoring: Review quarterly progress reports from website; review training participants' attendance forms; review materials distribution reports.

Activity 3: Assist Texas hospitals and birthing centers to become accredited through the Texas Ten Steps.
Output Measure: Number of application packets received for approval; number of letters sent; number of new hospitals and birthing centers accredited; number and type of TA contacts made; number of Mother-Friendly Worksite Program applicants.
Monitoring: Track progress in providing training and technical assistance as requested and follow up with the accreditation process.

Activity 4: Provide breastfeeding training and resources, including information about African American Breastfeeding Promotion, to physicians and other health care professionals by using

multiple methods, including distribution of educational materials and conducting training programs.
Output Measure: Number of training sessions provided; number of physicians or health care professionals participating in training by race and ethnicity; report on the number and type of strategies developed to involve physicians in breastfeeding promotion; number of hits on Resources for Physicians website; number of Physicians' Pocket Guide distributed.
Monitoring: Track progresses in providing training and technical assistance as requested; document training schedule and attendance.

Activity 5: Assist Texas worksites to become designated through the Mother-Friendly Worksite Program (MFWP) and provide follow-up support to designated sites.
Output Measure: Sample policies posted on website; number of MFWP materials distributed; database of current and new designees developed to facilitate communication and support; completed report on evaluation of MFWR; number of Texas Ten Steps applicants; number and type of TA contacts made; number of new worksites designated.
Monitoring: Track progress in increasing the number of worksites designated, providing technical assistance as needed, and completing the MFWR evaluation.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	10	46	92	92	92
Annual Indicator	12.2	30.8	84.3	82.4	88.2
Numerator	45000	113972	313116	309701	337998
Denominator	368019	370258	371429	375898	383268
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Update: On a weekly basis, Texas birthing facilities covered by the newborn hearing screening mandate electronically transmit to the DSHS contractor the records of all babies screened. The DSHS contractor tabulates the results on a monthly basis. The DSHS Newborn Hearing Screening reported 98.18% of babies screened from reporting facilities for FY04.
Birthing facilities are required by Texas law to be certified by DSHS and meet specific

performance standards. Currently there are 194 birthing facilities reporting data to DSHS on a weekly basis. Facilities are noted as being out of compliance if their NBHS program is below any of the standards for two of the three months in a quarter. Therefore, data are viewed as individual quarters. The following is a quarterly summary of the number of facilities out of compliance: 1st Quarter: 9 (1%); 2nd Quarter -- 4 (1.2%); 3rd Quarter -- 3 (2%); and 4th Quarter -- 5 (2.15%).

Performance assessment: In FY04, 337,998 screens were conducted, representing 88.2% of births, a significant increase in the 82.4% screened in FY03. With the passage of mandatory testing in 2000, the percentage has steadily increased but there is still room for improvement in achieving the 92% target objective. Not all hospitals in Texas are required to report screening rates. For those for which reporting is mandatory, or for those that voluntarily choose to report, screening rates exceed 98%. Program activities for FY05 include ongoing technical assistance and use of the new web-based system to enhance reporting and compliance.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.

Update: On a weekly basis, Texas birthing facilities covered by the newborn hearing screening (NBHS) mandate electronically transmit to the DSHS contractor the records of all babies screened. The DSHS contractor tabulates the results on a monthly basis. Birthing facilities are required by Texas law to be certified by the DSHS and meet specific performance standards. A facility is noted as being out of compliance if the NBHS program is below any of the standards for two (2) of the three (3) months in a quarter. Currently, there are 196 birthing facilities reporting data to DSHS on a weekly basis. For the 1st quarter, 98% of newborns were screened for hearing before hospital discharge, with three facilities out of compliance. For the 2nd quarter, 98% of newborns were screened for hearing before hospital discharge, with five facilities out of compliance. Facilities that are out of compliance are notified monthly through email by the contractor and through certified mail by the department if the issues continue during month three after the notification. The contractor works with facility staff to identify

solutions to the compliance issue(s).

c. Plan for the Coming Year

Activity 1: Conduct monitoring of mandated newborn hearing screening programs to verify that they meet certification criteria and evaluation using the data and software system established to manage the program.
Output Measure: Number of programs monitored by region, percent of compliant versus noncompliant programs.
Monitoring: Document the results of monitoring through monthly reports generated by electronic monitoring system developed for this project.

Activity 2: Conduct Texas Early Hearing Detection Intervention (EHDI) Coalition meetings every other month.
Output Measure: Number of meetings occurring, number and types of topics discussed and resulting changes and/or improvements, and names of organizations participating.
Monitoring: Track progress of coalition meetings on quarterly basis.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	23	22	20	20
Annual Indicator	23.0	21.3	22.4	20.0	21.6
Numerator	1353955	1271265	1341023	1207546	1316236
Denominator	5886759	5968378	5986708	6037731	6086973
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	20	20

a. Last Year's Accomplishments

Activity 1: Monitor and report the percentage of children without health insurance.

Update: Title V staff proactively monitor CHIP and Medicaid enrollment figures on a monthly basis and continue to monitor the number of eligible clients who receive services through Title V-funded contractors.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Update: All Title V contractors actively screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility. If the client is found to be eligible for CHIP or Medicaid, contractor staff assist with the completion of the application form. Otherwise, the client receives Title V services as a last resort.

Performance assessment: In FY03, 1,207,546 or 20% of children under 18 were uninsured, which met the state target of 20% and was an improvement over FY02. The projected percentage for FY04 is 21.6% and may be attributed to a sluggish economy and lower enrollment in Medicaid and CHIP programs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and report the percentage of children without health insurance.				X
2. Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monitor and report the percentage of children without health insurance.

Update: Title V staff proactively monitor CHIP and Medicaid enrollment figures on a monthly basis and continue to monitor the number of eligible clients who receive services through Title V-funded contractors.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Update: All Title V contractors actively screen all clients at Title V funded clinics for potential CHIP and Medicaid eligibility. If the client is found to be eligible for CHIP or Medicaid, the contractor's staff assist with the completion of the application form. Otherwise, the client receives Title V services as a last resort.

c. Plan for the Coming Year

Activity 1: Monitor and report the percentage of children without health insurance.
Output Measure: Percent of children without health insurance.
Monitoring: Follow progress in developing periodic child health insurance status report.

Activity 2: Screen all clients at Title V-funded clinics for potential CHIP and Medicaid eligibility and make referrals to appropriate programs.

Output Measure: Percentage of children without health insurance who are enrolled into CHIP and other state-funded insurance programs as identified by Title V contractors.
Monitoring: Follow up on each referral.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50	52	52	53	53
Annual Indicator	63.4	51.8	55.4	60.0	62.1
Numerator	674121	679567	846963	1098882	1253626
Denominator	1063394	1312697	1529942	1831982	2017859
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	60	60	60

Notes - 2003

Sources:
CMS-416, 1997-2003
Census 2000
Population estimates from Texas A&M University, BVS as of 05/2003.

Note: Expected eligibles from CMS-416 will serve as a better estimate of the potential THSteps particiapnts than Census estimates for most of the decade between Census 2000 and 2010.

Notes - 2004

Source:
CMS-416 FFY 1997-2004

a. Last Year's Accomplishments

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Update: Title V staff work closely with the Research and Public Health Assessment Office and the Texas Health Steps (EPSDT) Program to monitor the ratio of Medicaid Child recipients receiving Medicaid services. Analyses are done on an annual basis at the time of grant renewal.

Performance assessment: FY04 data indicate that 1,253,626 or 62.1% of Medicaid-eligible children received services, exceeding the state target of 53% and increasing from 60% in

FY03. Increases may be attributable to mandated enhanced outreach and increased efforts to inform families of children enrolled in Medicaid.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.

Output Measure: Number of Medicaid children birth through age 20 who received a Medicaid service, number of children birth through age 20 who are potentially Medicaid eligible.
Monitoring: Follow progress in updating report.
Evaluation: Analyze trends of the number of potentially Medicaid eligible receiving a Medicaid paid service.

Update: Title V staff work closely with the Research and Public Health Assessment Division and the Texas Health Steps (EPSDT) Program to monitor the ratio of Medicaid child recipients receiving Medicaid services. Analysis is done on an annual basis at the time of grant renewal.

c. Plan for the Coming Year

Activity 1: Monitor and report the ratio of Medicaid child recipients who receive a Medicaid service compared to the population of all children who are potentially Medicaid eligible.
Output Measure: Number of Medicaid children birth through age 20 who received a Medicaid service, number of children birth through age 20 who are potentially Medicaid eligible.
Monitoring: Follow progress in updating report.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.2	1.1	1.1	1	1
Annual Indicator	1.3	1.3	1.3	1.4	1.4
Numerator	4605	4808	4976	5133	5159
Denominator	363325	365092	372369	377374	378539
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1	1	1	1	1

a. Last Year's Accomplishments

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (e.g., African American women of childbearing age), and provide regional staff and health care providers with data and information on strategies to reduce the occurrence of very low birth weight live births. Provide data and information on the Perinatal Health website.

Update: The Perinatal Health Program Coordinator is finalizing data reports for distribution to each health service region (HSR) that include information on very low birth weight births (VLBW) and strategies to prevent VLBW. The HSRs use the data for educating providers and for strategic planning at the local level. Work continued on the development of the Perinatal Website throughout FY04, but posting of the website was interrupted due to the ongoing evaluation of the DSHS website.

Activity 2: Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS).

Update: In FY04, PRAMS presentations were given to the DSHS community, the Texas Birth Defects Research Symposium, and the PRAMS Advisory Committee to update participants on PRAMS implementation in Texas. In FY04, the PRAMS response rate ranged from 57% to 68%.

Activity 3: Provide ongoing support to the March of Dimes 5-year Prematurity Campaign.

Update: Throughout FY04, Title V staff collaborated with and supported the March of Dimes (MOD) 5-year Prematurity Campaign. Title V staff also participated in the Preemie Posse Kick-off event in November, 2003. The program arranged for parents of older babies who were born premature to share their knowledge and experiences with new parents of premature infants in a peer assistance effort to cope with the difficulties of parenting premature infants. MOD funded 16 proposals intended to reduce the incidence of prematurity in Texas. The funded entities will implement strategies in FY05 to increase opportunities for prenatal care, set up incentive programs for entering and complying with prenatal care, use promotoras to work with high-risk pregnant women, and develop and distribute health promotion and education materials. Title V staff also assisted with planning for the Austin Prematurity Summit held in May, 2004. The summit was designed as a call to action for community leaders and the 75 attending leaders to

take an active role in the prematurity prevention. State HHS leaders, business leaders, and a local MOD ambassador family made presentations.

Performance assessment: FY04 data indicate that 1.4% of babies are born with low birth weights, which is the same percentage as FY03 and exceeding the state target of 1%. Demographic data indicate the need to address racial/ethnic and age disparities for teens and African American women. As a result, in FY06, the Title V program will be funding projects with best practices in target areas and population groups to improve birth outcomes.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to assess the level and type of interventions needed for each target area and related sub-populations at risk and provide regional staff and health care providers with data and information on the Perinatal website.				X
2. Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS).				X
3. Provide ongoing support to the March of Dimes 5-year Prematurity Campaign.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Continue to assess the level and type of interventions needed for each target geographic area and related sub-populations at risk (e.g., African American women of childbearing age), and provide regional staff and health care providers with data and information on strategies to reduce the occurrence of very low birth weight live births. Work with regions with documented higher prevalence of very low birth weights to implement interventions targeted at reducing very low birth weight. Provide data and information on the Perinatal Health website.

Update: DSHS Title V staff reviewed the most recent statistics on low birth weights to determine which regional or other geographic designations of the state should be targeted for activities to prevent low birth weights. Title V staff participated in a web cast entitled Racial-Ethnic Disparities in Birth Outcomes in August, 2004, and presented the information to other staff members for discussion. Title V staff also contacted staff from several other states that utilize regional perinatal systems to discuss best practices. Staff continued to work with the Texas Healthy Start Association (THSA) and the March of Dimes to develop methods to address disparities in birth outcomes, including means of educating health professionals and the general public. Staff also worked with THSA on plans for a Region VI Conference and THSA annual education conference.

Activity 2: Provide ongoing support to continue implementation of the Pregnancy Risk Assessment Monitoring System (PRAMS); to improve overall PRAMS response rate, and to share and/or use PRAMS data, as appropriate.
Update: Four batches of PRAMS surveys were sent out in the first two quarters with sample sizes of 287, 230, 245 and 318. In addition, seven batches of responses were received during the two quarters yielding 1107 returned surveys with a response rate varying from 56.3% to 67.55%. No presentations were made on PRAMS in the first quarter, and no PRAMS Advisory Committee meetings took place. A poster session, A Comparison of Sources Used for Telephone Phase Phone Numbers, was presented at the PRAMS National Meeting on December 6-7, 2004, in Atlanta, GA.

Activity 3: Work closely with the March of Dimes 5-year Prematurity Campaign.

Update: Title V staff participated in one March of Dimes (MOD) Prematurity Campaign meeting during the first quarter and submitted a report of relevant DSHS activities to the MOD Program Services Committee. In addition, Title V staff attended the Fort Worth MOD Prematurity Summit and the Assistant Commissioner for Community and Family Health Services spoke at the Dallas MOD Prematurity Summit.

Title V staff participated in one March of Dimes (MOD) Prematurity Campaign meeting during the second quarter. Also Title V and MOD staff discussed discrepancies in DSHS data and the Texas data reflected in national health data for prematurity.

c. Plan for the Coming Year

Activity 1: Using Geographic Information Systems (GIS) and related data sets (i.e., PRAMS and birth certificates), identify areas and subpopulations with the highest incidence of very low birth weight births and compare the incidence to known risk factors (i.e., teen pregnancy, fetal exposure to tobacco, pre-pregnancy weight, utilization and onset of prenatal care, previous low or very low birth weight infant).
Output Measure: Number of areas with very low birth weights identified; summary report comparing areas with high incidence of very low birth rates to known risk factors.
Monitoring: Identify data needed and review development of GIS maps.

Activity 2: Allocate funds through a population-based competitive Request For Proposals (RFP) in targeted areas/subpopulations of the state to obtain the best birth outcomes.
Output Measure: List of models or best practices for improving birth outcomes; list of target areas, list of awards made, quarterly reports of contract performance.
Monitoring: Review contractor activities and progress.

Activity 3: Work with Texas Healthy Start projects to implement a peer counselor/promotora (PCP) model for high-risk pregnant women to be connected with a PCP who serves as a resource for the pregnant women in helping them address known risk factors (i.e., discontinuing smoking, reducing stress, ensuring appropriate weight gain during the pregnancy, keeping prenatal appointments and preventing a subsequent pregnancy too soon after delivery).
Output Measure: Number of Healthy Start projects involved; PCP curriculum identified; number of peer counselor program training offered; number of providers trained to implement a PCP program; number of PCP trained; number of clients connected with a PCP.
Monitoring: Review number of PCP trained by providers. Review number of clients connected with a PCP.

Activity 4: Work closely with the March of Dimes (MOD) Prematurity and African American Outreach Campaigns.
Output Measure: Number of campaign planning meetings participated in; number of

presentations made; number and type of state program services committee meetings participated in; number of MOD data requests filled.
Monitoring: Document minutes of meetings and conference calls with MOD.

Activity 5: Work with Research & Public Health Assessment (R&PHA) to conduct a Perinatal Periods of Risk (PPOR) assessment of DSHS birth data.
Output Measure: List of data sources; PPOR analysis completed, including recommendations for best practices; number of presentations made to stakeholders and/or information on the Internet regarding the PPOR analysis process and outcome; set of recommendations.
Monitoring: Track development and implementation of PPOR outcome.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	11	10.5	10.5	10	10
Annual Indicator	9.4	7.6	9.0	9.5	8.5
Numerator	154	127	149	162	142
Denominator	1636232	1663111	1653654	1701620	1677149
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	8.2	8.2	8

Notes - 2003

1991-1998 Deaths from TDH, Bureau of Vital Statistics, Texas A&M University, Texas State Data Center, Mortality Files, May 2003 (ICD-9 Codes 950-959)
1999-2001 Deaths from TDH, Bureau of Vital Statistics, Mortality Files (ICD-10 Codes from List of 113 Selected Causes of Death, Numbers 105-106)
Population from TDH, Bureau of Vital Statistics, Texas A & M University, Texas State Data Center, Population Estimates, May 2003

a. Last Year's Accomplishments

Activity 1: In the continued effort to create statewide suicide prevention plan, work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.

Update: The Texas Suicide Prevention Network, which supports the DSHS Texas Strategic Partnership, developed and distributed a suicide prevention tool kit for Texas communities through the Mental Health Association of Texas. The Texas Suicide Prevention Network

secured funding from the legacy agency, the Department of Mental Health & Mental Retardation to create a community tool kit in conjunction with a statewide conference for suicide prevention. The conference was held on August 11, 2004, in Austin. A total of 11 communities (Austin and surrounding area, Dallas, East Texas, Fort Worth, Fredericksburg, Houston, Llano & Burnet, San Antonio, Victoria and Waco) were represented at the conference. The suicide prevention toolkit was published on the internet on August 31, 2004, and is available for download at the Mental Health Association of Texas website. The network established a monthly electronic newsletter, which includes updates in local communities and upcoming events and workshop in Texas. On August 10, 2004 Governor Rick Perry issued a suicide prevention proclamation recognizing September 5-11, 2004, as Suicide Prevention Week in Texas.

A new workgroup, Texas Adolescent Mental Health in Primary Care, was formed in 2004 to utilize a collaborative effort to promote mental health screens for adolescents in primary care settings. Plans include application for funds and identification of a pilot site for implementation.

Performance assessment: In FY04, Texas' rate of suicide death among youths aged 15-19 continued to decline to 8.5 per 100,000, a moderate decline from 9.5 reported in FY03. There will be a continuation of activities in FY06 including local coalitions around the state that address adolescent mental health issues, the Texas Suicide Prevention Network's promotion of teen suicide prevention strategies, and the DSHS Adolescent Mental Health workgroup's focus of mental health screens for adolescents in primary care settings. Additionally, notice of award announcement is pending for funds to provide youth suicide screening, prevention, and early intervention services as well as collaboration with the Policy Academy to develop a plan to improve services for people with co-occurring substance abuse and mental disorders.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In the continued effort to create statewide suicide prevention plan, work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Participate in the Texas Suicide Prevention Partnership in the continued implementation of the state suicide prevention plan.

Update: The Texas Suicide Prevention Network offers resources to community network partners in preparation for Suicide Prevention week. Suggestions included an information and

media kit provided by the American Association of Suicidology, a planning guide for increasing awareness among legislators and other key leaders in the community, free mental health promotion materials both in Spanish and English, the "how to" in organizing an advocacy letter-signing event and websites which provided an array of resources. In conjunction with National Suicide Prevention week activities, a local television station in Austin, Texas, featured the Texas Suicide Prevention Network.

The Fort Worth Community Network sponsored two seminars on suicide. The first one focused on suicide in older adults. The program was entitled "Understanding Depression and Preventing Suicide in Older Adults," and the Mental Health Association of Tarrant County co-sponsored this event. The second event provided training for counselors and administrators from at least 26 schools in the Fort Worth, Lewisville, Carroll and Grapevine-Colleyville school districts. The study kit given at the workshop provided a staff procedure manual and training video, student screening forms, educational videos, and discussion guides and brochures on suicide and depression for students and parents.

In November, 2005, the Central Texas Chapter of the American Foundation for Suicide Prevention, in cooperation with the Austin Travis County MHMR Center and Hospice Austin, sponsored a teleconference during National Survivors of Suicide Day.

As a result of the distribution of the suicide prevention tool kits, a number of communities have established coalitions, including Waco-Temple "Heart of Texas", the newly established Fredericksburg-Kerrville "Hill Country" and San Antonio. The Austin coalition has also made progress in securing participation with the Austin Independent School District.

The Texas Suicide Prevention Network offered input to the Texas Legislative House Bill 470, relating to local delivery of aging, disability, behavioral health, and mental retardation services.

Will Wynn, the mayor of Austin, Texas, announced a report from the local Mental Health Taskforce. The Task Force is the culmination of several years of community concern over the challenges faced by residents with severe mental illnesses. Mayor Wynn created the Task Force in August, 2004. More than 80 individuals representing over 40 organizations participated over a period of five months to identify the strengths and gaps in mental health services in the community, develop criteria that define a mentally healthy community and create an action plan to close the gaps in the community.

c. Plan for the Coming Year

Activity #1: Provide support to the Texas Suicide Prevention Community Network in the implementation of the state suicide prevention plan. The state plan includes identifying resources for targeted communities with the highest incidence of suicide in the state.
Output Measure(s): Number of communities enrolled in the network; number and type of activities implemented in the targeted communities to prevent suicide; number and type of grants applied to; number and types of grants secured to further advance the state plan goals.
Monitoring: Track the progress of the Network and activities within each local participating community.

Activity 2: Through the Texas Adolescent Mental Health in Primary Care Initiative Workgroup, develop a work plan to conduct mental health screening in primary care through a pilot project.
Output Measure(s): Workplan developed; progress report on activities related to the implementation of a pilot site to screen youth for mental health disorders in primary care settings.
Monitoring: review of quarterly progress reports relating to the activities of the workgroup and

the pilot project.

Activity 3: Submited an application for funding (awaiting for award announcement) to provide youth suicide screening prevention and early intervention services by 1) incorporating training of health, school and community representatives to identify and refer at-risk youth; 2) supporting collaborative efforts of state suicide prevention organizations to increase public awareness; and piloting a health care initiative to identify, assess, and provide referral and follow-up in Houston, Austin, and San Antonio.
Output Measure(s): Application submitted; number of training sessions provided; public awareness activities implemented; number of clients seen through the pilot.
Monitoring: Track the development and submission of the application packet and document training sessions provided and the number of clients seen.

Activity 4: Collaborate with the Policy Academy to develop a state action plan designed to improve services for people with co-occurring substance abuse and mental disorders.
Output Measure(s): State action plan completed; list of major deliverables completed.
Monitoring: Track progress on the completion of the state action plan and the implementation of major deliverables.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	55	55	55	55	55
Annual Indicator	52.2	52.6	53.5	52.9	52.4
Numerator	2402	2530	2660	2674	2690
Denominator	4605	4808	4976	5053	5133
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	55	55	55

a. Last Year's Accomplishments

Activity 1: Develop and implement a process for the self-designation of perinatal care facilities as basic, specialty or subspecialty.

Update: A self-designation process was discussed and drafted at the Perinatal Systems meeting in November, 2003. Title V staff were tasked during this meeting to learn more about information already collected by DSHS on levels of care designation. Due to the organizational changes resulting from the consolidation that occurred in 2004, DSHS leadership temporarily discontinued the workgroup and no additional action was undertaken in FY04.

Performance assessment: As in FY03, the percentage of VLBW deliveries at facilities for high-risk deliveries and neonates remained below the 55% objective at 52.4% in FY04. This percentage has remained relatively consistent over the last five years. Efforts to improve Texas' progress on this measure include activities to improve local existing perinatal systems.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement a process for the self-designation of perinatal care facilities as basic, specialty or subspecialty.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty.

Update: Title V staff worked with the DSHS Regulatory Licensing Unit and the DSHS Center for Health Statistics to determine the level of care in Texas Hospitals that routinely provide MCH services. Title V staff created a list of hospitals by level of care for distribution to each of the health service regions and for posting on the DSHS website by the end of FY05.

c. Plan for the Coming Year

Activity 1: Develop a process to facilitate appropriate referrals for at-risk clients to facilities for high-risk deliveries and neonates and ensure the continued assessment of perinatal care facilities as basic, specialty or subspecialty by using Geographic Information Systems (GIS) maps, developing and disseminating educational materials for providers, solicitating input from stakeholders, and tracking referral patterns in selected areas.
Output Measure: Number of referrals (origins/destinations) made for at-risk clients to facilities for high-risk deliveries; number of GIS maps developed; number and type of materials developed; number of materials distributed; number of stakeholder meetings convened; number of stakeholder organizations represented at meetings.
Monitoring: Document minutes from stakeholder meetings and track referral patterns.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85	85	85
Annual Indicator	76.2	77.7	79.3	79.7	81.3
Numerator	276720	283822	295282	300927	308132
Denominator	363325	365092	372369	377374	379077
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85	85	85

a. Last Year's Accomplishments

Activity 1: Provide county specific data fact sheets regarding entry into prenatal care to regional Title V staff and local health care providers. Provide information on strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester to regional staff and health care providers. Provide data and information on the Perinatal Health website.

Update: The DSHS Center for Health Statistics developed reports on perinatal health issues for each DSHS HSR. The reports included information on entry into prenatal care and strategies to increase early entry into prenatal care. Title V staff continue to work with the Center to tailor the reports to the unique needs of each HSR. Potential best practice models include the concept of group prenatal care and the Friendly Access Program operating out of the Lawton and Rhea Chiles Center for Healthy Mothers and Babies (http://www.chilescenter.org/programs4.htm). Title V staff also discussed the possibility of hosting a training on group prenatal care for Title V-funded contractors and have contacted New Mexico Health Department staff regarding similar centering pregnancy efforts .

Activity 2: Work with March of Dimes and state Area Health Education Centers to train Promotoras/Community Health Workers to provide folic acid information and multi-vitamin samples to women of childbearing years.

Update: During FY 04, multivitamins were ordered and a plan was developed for disseminating multivitamins to promotoras/community health care workers. An order form, which is distributed at promotora training events, was developed to order the multivitamins and promotional materials. In FY04, DSHS distributed more than 2,000 units of vitamins to promotoras.

Activity 3: Improve the outcomes of pregnancies impacted by diabetes among the African American and Hispanic populations through the provision of data and technical assistance to the public health regions, local health care providers and the general public.

Update: The perinatal health coordinator is modifying data reports on the impact of Type I and Type II diabetes on pregnancy for each public health region. Work continued on the development of the Perinatal Website throughout FY04, but posting of the website is pending

due to the state agency consolidation impact on priority of website revisions

Performance assessment: FY03 data indicate that 79.7% of infants were born to women who received prenatal care beginning in the first trimester, which is a slight increase over 79.3% in FY02 but still below the state target of 85%. Demographic data indicates a need to improve strategies to link teens and African American women to early prenatal care. Activities to educate providers and target the populations most in need will continue. Title V will release a competitive RFP in FY06 to fund projects in target areas and population groups with low utilization of prenatal care to improve birth outcomes.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide county specific data fact sheets regarding entry into prenatal care to regional and local staff and providers. Provide information on strategies to increase the precent of infants born to women receiving prenatal care begining the first trim				X
2. Work with March of Dimes and state Area Health Education Centers to train Promotoras/Community Health Workers to provide folic acid information and multi-vitamin samples to women of childbearing years.				X
3. Improve the outcomes of pregnancies impacted by diabetes among the African American and Hispanic populations through provision of data and technical assistance to the public health regions, local health care providers and the general public.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Provide region specific data fact sheets regarding entry into prenatal care to regional Title V staff and local health care providers targeting high risk, high prevalence areas. Provide information on strategies to increase the percent of infants born to women receiving prenatal care beginning in the first trimester to regional staff and health care providers. Partner with TDH Quality Assurance Program to assess access to care among TDH contractors. Provide data and information on the Perinatal Health website.

Update: Region-specific data fact sheets are still under development. As noted in NPM 15, Activity 1, Title V staff have researched and discussed several best practices that could serve as models for activities and strategies to increase early prenatal care in the DSHS public health regions.

Title V staff presented on the Centering Pregnancy Model at the annual Association of Maternal and Child Health Programs meeting in Washington, D.C. The presentation compared birth outcomes for pregnant Hispanic teen clients at a freestanding birthing center that uses the

Centering Pregnancy Model with outcomes for all pregnant Hispanic teens in Texas in the same year. Title V staff presented information on prenatal care and how to access it on a health program targeted to Spanish-speaking families in Central Texas on KOKE AM Radio station.

Activity 2: Improve the outcomes of pregnancies impacted by diabetes among the African American and Hispanic populations through the provision of data and technical assistance to the public health regions, local health care providers and the general public.

Update: Data on Type I and Type II diabetes among pregnant women in Texas are currently unavailable. In January, 2005, Texas began using a new birth certificate that will enable use of data related specifically to Type I, Type II and gestational diabetes. Due to the consolidation of health and human services in Texas and the reorganization of the state health department, posting of Type I and Type II diabetes data on the perianatal webpage is pending

c. Plan for the Coming Year

Activity 1: Through the Texas Comprehensive Women's Health Initiative grant, implement a process to develop and implement an action plan to improve the comprehensiveness of the women's health care service delivery system in DSHS HSRs 9/10 and 11, predominantly Hispanic areas with low utilization of early entry into prenatal care.
Output Measure: Complete and release a bidding process to select a contractor in each target area to implement grant activities, contract awards made, action plan developed in each PHR; number of women referred into care through the comprehensive service delivery system in each PHR.
Monitoring: Document the planning process, action plan development and track the referral patterns.

Activity 2: Allocate funds through a population-based competitive Request For Proposals (RFP) in targeted areas/subpopulations of the state to obtain the best birth outcomes. (same as NPM 15, Activity 2 -- low birth weights.)
Output Measure: List of models and/or best practices for improving birth outcomes; list of target areas, list of awards made, quarterly reports of contract performance.
Monitoring: Review contractor activities and progress.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Change in institutionalized CSHCN, as percent of previous year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	95	90	90	90
Annual Indicator	99.4	96.2	101.8	92.9	98.3

Numerator	1253	1206	1228	1141	1590
Denominator	1260	1253	1206	1228	1617
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	95	90	85	80

Notes - 2003

Source:
http://www.hhsc.state.tx.us/pubs/20021231_SB368_PPR.html

Notes - 2004

Beginning in FY2004 the indicator for this performance measure is changed from a comparison to the previous year to a comparison to the base year, FY2003. Additional congregate care settings for children are included, raising the number of children living in congregate care settings in the base year, 2003, from 1141 to 1617.

Source:
Texas Health and Human Services Commission Office of Program Coordination for Children and Youth.

a. Last Year's Accomplishments

Activity 1: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions and congregate care facilities.

Update: CSHCN SP staff participated in 11 statewide groups addressing issues of children in, or at risk of being placed in, institutions. Issues included improving access to services; ensuring that children's issues and expertise in children's policy and program not get lost in the HHS system reorganization; improving transition to adult services; enhancing interagency collaboration; and fostering self-determination among CSHCN. Participants voiced concern about reductions in state budgets for health and human services for children and the potential for increasing institutionalization. Program staff also participated on the statewide Children's Policy Council and the Texas Integrated Funding Initiative that developed recommendations to state leaders regarding permanency planning and deinstitutionalization of children.

CSHCN SP policies were modified to allow applications for children living in nursing homes. The CSHCN SP covers services not provided in nursing home benefits and offers family support services (FSS) to help CSHCN moving to a family home.

Activity 2: Provide FSS for CSHCN and their families to enable CSHCN to live with their families in the community.

Update: In FY04, the vast majority of CSHCN SP FSS were provided through contractors, serving 5441 families of CSHCN. Due to a waiting list for the fee-for-service CSHCN SP health care benefits, the program was able to provide fee-for-service family support services only to children at risk of institutionalization or if cost effective for the program. Of 8 requests for fee-for-service FSS, 3 were approved, including 2 for vehicle modifications and 1 for respite. Of the 3 approved FSS requests, 1 was based on cost effectiveness for the CSHCN SP, and 2 were to help prevent out-of-home placements.

Additional activities included revision of the CSHCN SP fee-for-service FSS request, decision, authorization, and reimbursement procedures, forms, and correspondence templates; revision of data collection process/tools; and meetings with the Regional Directors of Social Work to get input and to provide training and technical assistance on FSS.

Performance Assessment: In FY04, the number of children residing in nursing facilities, ICF/MR facilities, and state schools showed a decline of 4.8% from FY03 and 13.3 % from FY00. However, the number remains above 1000. CSHCN SP will continue collaborating with other state agencies and private organizations to support children living in families. As funding permits, CSHCN SP will make FSS available to clients at risk of institutionalization and to clients living in congregate care who are moving to families.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in state-level committees/taskforces to collaborate with multiple partners to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions.				X
2. Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community.		X		
3.				
4.				
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b. Current Activities

Activity 1: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and community living options for CSHCN who are at risk for placement or who currently reside in institutions and congregate care facilities.

Update: CSHCN program staff participate in 11 statewide groups addressing issues of children in, or at risk of being placed in institutions. Major issues addressed by the statewide groups include: improving access to children's services; ensuring that issues and expertise in children's policy and program not get lost in the HHS system reorganization; improving transition to adult services; preserving and enhancing effective interagency collaboration in serving children with complex needs; and fostering self-determination among CSHCN as they mature and transition to adults services.

The CSHCN Health Care Benefits program accepts applications for children living in nursing

homes. For eligible clients, the program covers services not covered in their nursing home benefit package, including family support services, to help them return home.

Activity 2: Provide family support services for CSHCN and their families to enable CSHCN to live with their families in the community.

Update: By the end of the 2nd quarter, CSHCN SP contractors provided family support services to 3,937 CSHCN. Because of the a waiting list for CSHCN health care benefits, family support services are limited to children on the Program who are at risk of institutionalization or for whom provision of FSS is cost effective for the CSHCN SP. Provision of family support services by contractors is not subject to the same limitations.

Central Office staff received 22 requests for family support services. Of these, 17 were approved for full or partial funding, 3 are pending and 2 were denied for not meeting the criteria. Fourteen CSHCN client families had received family support services from the CSHCN SP health care benefits as indicated by claims payments. The CSHCN SP received no applications for family support services for children leaving nursing homes.

c. Plan for the Coming Year

Activity 1: Provide, or support the provision of, permanency planning (including alternative families where appropriate and available) and case management services to families of CSHCN suspected to be at risk of, or in, out-of-home placement.
Output Measure(s): Number of CSHCN assisted with permanency planning by CSHCN Services Program regional case management staff, including assistance with the development and/or implementation of permanency plans; number of placements of CSHCN with alternative families, if data are available; number of admissions and discharges for CSHCN from congregate care settings (nursing homes, state schools, ICFs-MR), if data available.
Monitoring: Review quarterly CSHCN Services Program regional staff and contractor case management reports and data from the Health and Human Services Commission.

Activity 2: Fund respite programs and other family support services programs through contracts and CSHCN Services Program Health Benefits.
Output Measure(s): Number of respite and other family support services grants awarded; number of CSHCN families served; number of families provided respite and other family support services.
Monitoring: Review of quarterly reports from the CSHCN Services Program health care benefits database (CMIS).

Activity 3: Participate in state-level committees/task forces to collaborate with consumers, providers, and other state and private agencies to support permanency planning and family-based community living options for CSHCN who are at risk of placement or who currently reside in institutions or congregate care settings.
Output Measure(s): Number and type of state-level meetings attended by CSHCN Staff; list of related recommendations/actions.
Monitoring: Review of stakeholder reports on relevant meetings attended by CSHCN Services Program staff.

State Performance Measure 2: *Percent of children and adolescents (aged 13-19) who choose healthy behaviors*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	69	70	71	72	73
Annual Indicator	69.1	62.5	60.1	55.1	58.8
Numerator	1577994	1451817	1390485	1287541	1392660
Denominator	2283133	2321233	2313512	2336598	2369548
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74	74	74	74	74

Notes - 2003

Sources:
http://www.tcada.state.tx.us/research/survey/grades7-12/SchoolSurvey2002.pdf (p24)
http://www.tea.state.tx.us/research/pdfs/0102drpt.pdf (p47)
CMS-416 FY 2003
TDH, HIV/STD
TDH, BVS

a. Last Year's Accomplishments

Activity 1: Provide training on youth risk reduction and youth health promotion to health care and educational professionals at regional Education Service Centers.

Update: A total of 26,023 participants were trained in 999 workshops, which covered 126,202 clock hours. The average workshop evaluation was 4.5 on a scale of 1-5. Following is a summary of achievements for the year:

Standardized assessment of regional training needs was established.
Portfolio assessment of regional trainings to share with other regions.
Focus on local School Health Advisory Councils to ensure local values and norms are included in risk
reduction training.
Improved timely monthly data reports submitted by contractors have occurred. Timeliness of reporting
is part of evaluations process.
Bi-annual meeting of contractors to share ideas and resources regarding training and increasing
attendance at training.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities. (Same as Activity #2, National Performance Measure 8 -- birth rate).

Update: The Abstinence Education Program served 279,928 unduplicated clients in FY04. The priority population was defined as the group most likely to have impact on federal, state and local performance measures, such as reduction of teen pregnancy and STDs and increased parental involvement. Approximately 82% of clients served were 10-17 years of age. Other demographic estimates include 30% African American, 50% Hispanic, and 46% male and 54% female. The program has a total of 42 contractors distributed across the health service regions, with a concentration of services in regions with dense population.

Performance assessment: In FY04, 58.8% of children and adolescents (13-19) chose healthy behaviors, an improvement over the 55.1% in FY03. Population-based activities to increase the number of children and adolescents who choose healthy behaviors will continue to be conducted in a variety of venues and systems, including schools and health care settings.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide training on youth risk reduction and youth health promotion to health care and educational professionals at regional Education Service Centers.				X
2. Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities.				X
3.				
4.				
5.				
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8.				
9.				
10.				

b. Current Activities

Activity 1: Provide workshops on youth risk reduction and youth health promotion to health care and educational professionals at Texas' regional Education Service Centers (ESC).

Update: To attain this measure, the Youth Focused Group monitors the activities of twenty contractors located in each of the regional Education Service Centers. These contractors provided 319 training sessions on youth risk reduction such as tobacco prevention, alcohol prevention, teen pregnancy, STDs, motor vehicle deaths, homicide, suicide and other risky behaviors and youth health promotion topics such as obesity prevention, physical activity and sun safety. There were 6,115 healthcare and education professional participants with 30,557 clock hours of training. The average evaluation for the trainings was 4.7 on a 1-5 scale, with 5 representing an excellent training.

Activity 2: Provide funding to community-based organizations to promote abstinence from sexual activities through strategies that include abstinence education, mentoring, counseling and adult supervised activities. (Same as Activity #2, National Performance Measure 8 -- birth rate).

Update: The Abstinence Education Program served 196,462 unduplicated clients in the first two quarters of FY05. The priority population is defined as the group most likely to have impact on federal, state and local performance measures, such as reduction of teen pregnancy and STDs and increased parental involvement. Approximately 77% of clients served were 10-17 years of age and 85% were ages 10-19. Other demographics include 54% females, 45% males, 16% African American, and 47% Hispanic. The program has a total of 38 contractors located across the DSHS public health regions.

c. Plan for the Coming Year

Performance Measure 2, the percent of children and adolescents (13-19) who choose healthy behaviors, is not carried over in FY06.

State Performance Measure 3: *Percent of infants and children (aged 0-12) who thrive*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	72	74	76	78	80
Annual Indicator	64.6	57.6	53.0	57.7	56.8
Numerator	2754540	2488296	2299469	2517613	2492896
Denominator	4263103	4321660	4339841	4366010	4390360
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80

a. Last Year's Accomplishments

Activity 1: Develop a statewide Early Childhood System (ECS) in conjunction with internal and external stakeholders. Recommendations will be included in a comprehensive state plan and presented to the Associateship of Family Health.

Update: Coordination of the Statewide Early Childhood Coordination System (SECCS) was transferred to the Health & Human Services agency in 2004. A SECCS grant coordinator was hired in August, 2004. The issue areas of the grant are early care and education, access to health insurance/medical home, parent education and family support, and social-emotional development/mental health. An evaluation of the current process indicated a need to assure that workgroups focus on system integration rather than programmatic issues. Other accomplishments include the establishment of a steering committee and collection of data from public and private stakeholders through surveys and focus groups. The purpose of the data collection was to examine the experiences of families with young children who access health and human services systems and early care and education programs. Data were not available

for review at the time of this report.

Activity 2: Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safeties. (Same as National Performance Measure 10, Activity 1)

Update: For the grant year ending Sept. 2004, Safe Riders conducted a total of 72 presentations to adults and children regarding child passenger safety and safety seats. See National Performance Measure 10, Activity 1 for additional details.

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8. (Same as Activity 2, National Performance Measure 10)

Update: In FY04, Safe Riders provided a total of 11,398 seats to 94 local programs throughout Texas and Safe Riders provided training for each program. From 125 to 175 local safety seat distribution classes were taught each month in Texas through this program. See National Performance Measure 10, Activity 2 for additional details
Activity 4: In the continued effort to create statewide suicide prevention plan; work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state. (Same as Activity 1, National Performance Measure 16)

Update: In FY04, the Texas Suicide Prevention Network provided a forum for a collaborative partnership to address teen suicide prevention. See National Performance Measure 16, Activity1, for additional details.

Performance assessment: FY04 projected percentage of children who thrive is 56.8%, a slight decrease from 57.7% in FY03. Data show slow progress toward the 80% target. Several Title V population-based and infrastructure-building activities are being implemented to reduce the gap between the current status and the target objective.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a statewide Early Childhood System (ECS) in conjunction with internal and external stakeholders. Recommendations will be included in a comprehensive state plan and presented to the Associateship of Family Health.				X
2. Provide traffic-seat safety presentations to children ages 0-8 regarding car seat safety.			X	
3. Provide high quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8.			X	
4. In the continued effort to create statewide suicide prevention plan; work with key stakeholders in enlisting broad base support through a grassroots campaign throughout the state.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Activity 1: In collaboration with HHSC's Office of Early Childhood Collaboration, and in conjunction with both external and internal stakeholders, participate in the development of a statewide Early Childhood System.

Update: The Office of Early Childhood arranged for the University of Texas Center for Disability Studies to conduct focus groups with parents of children under the age of six. The purpose was to learn about experiences raising children who access health and human services systems through early care and education. Eleven parent focus groups were held in 10 communities across the state. Participants were users of different types of services relevant to early childhood collaboration and were diverse in socio-economic, geographic and racial/ethnic status. There were a total of 112 participants, all parents of children under the age of six. Of the total, sixty-seven percent were Latino, 38% were Spanish speakers, 93% were female and 29% were parents of children with disabilities. Most were from two parent families (63%), a few (6%) were grandparents and three were foster parents.

A provider survey was conducted of health and human services professionals. There were 227 responses from 73 geographic areas. Most respondents were non-Hispanic females with almost half identifying as service providers, 66% providing early care and education, 64% providing parent education and 23% providing health care services (broadly defined by respondents).

The four workgroups (early care and education, access to health insurance/medical home, parent education & family support, social-emotional development/mental health) met on a monthly basis from September through November, 2004, to complete draft recommendations. A meeting followed in December, 2004, to finalize recommendations. Final recommendations included desired outcomes, strategies and activities for family support, parent education, early care and education, social-emotional development/mental health, and access to health insurance and medical home. HHSC staff began assessing the recommendations in January, 2005 for feasibility of implementation with existing resources.

Activity 2: Provide Child passenger safety presentation to children ages 0-8 regarding car seat safety. (Same as Activity 1, National Performance Measure 10 -- motor vehicle crashes)

Update: Through February, 2005, the Safe Riders Traffic Safety Program provided a total of 23 child passenger safety presentations to a total of 812 persons. See National Performance Measure 10, Activity 1 for more details.

Activity 3: Provide high-quality safety seats and education concerning their use to low-income families through a distribution program. Seats will be provided for children from birth to about age 8. (Same as Activity 2, National Performance Measure 10)

Update: Safety Seats for this fiscal year will be distributed during May -- June, 2005. See National Performance Measure 10, Activity 2 for more details.

c. Plan for the Coming Year

State Performance Measure 3, the percent of infants and children (aged 0-12) who thrive, is not carried over in FY06.

State Performance Measure 4: *Ratio of Black low birth weight (LBW) rate to White LBW rate*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective		1.6	1.6	1.6	1.6
Annual Indicator	2.0	1.9	1.8	1.9	1.8
Numerator	12.7	12.9	12.7	13.6	12.8
Denominator	6.5	6.9	7	7.3	7.2
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.6	1.6	1.6	1.6	1.6

Notes - 2003

SOurce:
TDH, Bureau of Vital Statistics, Texas Vital Statistics Annual Report, 1991-2002.

a. Last Year's Accomplishments

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in DSHS Public Health Regions 5 (Tyler) and 6 (Houston) by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.

Update: About twenty unduplicated calls by women aged 13 through 44 are made to the Great Start Smoking Cessation line per quarter. This line is specifically designed for pregnant callers. Three to four hundred unduplicated calls are made to the Quitline Smoking Cessation Line by women aged 13 through 44 per quarter. This line targets all women, however when a pregnant woman is identified she is referred automatically to the Great Start Smoking Cessation Line. Funding dedicated to this activity was reduced by over 50% of FY 03 levels and has resulted in lower overall call volume and reduction in expenditures for media promotion of the availability of hotlines.

Performance assessment: The FY04 rate of 1.8 shows a slight improvement over the FY03 ratio. Several strategies will be implemented, including a competitive RFP to target population groups to improve birth outcomes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promoting smoking cessation to African American women, including				

pregnant women by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.			X	
2.				
3.				
4.				
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6.				
7.				
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10.				

b. Current Activities

Activity 1: Promote smoking cessation to African-American women ages 13-44, including pregnant women in TDH Public Health Regions 5 (East Texas/Gulf Coast area) and 6 (Houston) by informing providers about smoking cessation programs and distributing information about smoking cessation counseling.

Update: Title V staff participated in a Smoking Cessation Workgroup focusing on pregnant women in DSHS Public Health Regions 5 (East Texas/Gulf Coast area) and 6 (Houston). During this time, the workgroup developed a process for referring WIC clients and others to the Great Start / Quitline, which is a pilot program in collaboration with the University of Texas at Austin. In the Great Start / Quitline model, WIC clients who self-identify as a smoker during intake with WIC staff are asked if they are willing to be contacted directly by Great Start / Quitline about discontinuation of smoking. If so, the client signs a permission form to be contacted for counseling and follow-up.

There were 58 calls to the Great Start Quitline from known pregnant women. By race/ethnicity, 33 were White, 15 were African American, seven were Hispanic and three were Other.

c. Plan for the Coming Year

State performance measure 4, the ratio of Black low birth weight (LBW) to White LBW, will not be carried over in FY06.

State Performance Measure 5: *The Prevalence of Childhood Obesity*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	20	19	17	16	15
Annual Indicator	21.9	23.2	24.1	10.8	9.8
Numerator	86533	92979	100071	47880	46010

Denominator	396021	400238	416010	445147	468967
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	15	15	15	15

Notes - 2003

Sources:
TDH, Bureau of Nutrition Services, 1998 & 2000-2004 Annual Nutrition Risk Reports
Tdh, Bureau of Nutrition Services, Texas WIN 1999, Certification and Nutritional Risk Tables

a. Last Year's Accomplishments

Activity 1: The Texas State Strategic Health Partnership Workgroup will expand the "Strategic Plan for the Prevention of Obesity in Texas" to be a comprehensive state plan. The plan will address 1) obesity prevention and control including caloric expenditure and intake; 2) increased consumption of fruits and vegetables; 3) increased physical activity; 4) reduced television time; and 5) increased breastfeeding.

Update: In October, 2003, a 47-member workgroup of the Texas State Strategic Partnership (TSSP) convened to address obesity prevention. Goal A of the TSSP is to improve the health of all Texans by promoting healthy nutrition and physical activity. The Goal A workgroup is composed of four subgroups, each assigned one of the goals in the Strategic Plan for the Prevention of Obesity in Texas and the associated action items. The subgroups recommended policies to improve nutrition and physical activity, conducted focus groups to develop obesity-prevention messages, reviewed best practice models for healthy nutrition and increased physical activity, and provided a recommendation for obesity surveillance. DSHS staff on the workgroup developed a timeline for updating the Strategic Plan for the Prevention of Obesity in Texas. Staff will continue participation in the workgroup and will solicit input from statewide partners for the plan update. When complete, the update will be a compendium to the original plan that provides a comprehensive implementation guide. As of June, 2004, the workgroup was temporarily on hold due to the DSHS consolidation.
Activity 2: Contract with the University of North Texas Health Science Center (UNTHSC) to conduct social marketing research to develop messages to use with the implementation of the "Strategic Plan for the Prevention of Obesity in Texas."

Update: A contract was executed with the UNTHSC. Contract staff conducted a literature review, reviewed Texas obesity data, and had conference calls with the workgroup to discuss the target audience for the social marketing campaign. The contractor conducted focus groups with Hispanic children, ages 9 through 13, and their parents to identify appropriate messages for a marketing campaign. A final report was submitted to DSHS detailing the results of the focus groups and making recommendations for a campaign to increase physical activity and improve nutrition among Hispanics.

Performance assessment: Before FY03, the measurement for obesity was calculated on the 90th percentile of height/weight in WIC children 1-5 but is now measured on the 95th percentile. This change in methodology most likely attributed to the drop in the percentage of obesity in FY03 to 10.8% from 24.1% in FY02. The FY04 prevalence is 9.8%. Activities related to improved nutrition and increased physical activity are key outcomes in the DSHS Strategic Plan for the Prevention of Obesity and obesity prevention remains a top priority for the department.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Texas State Strategic Health Partnership will expand the Strategic Plan for the Prevention of Obesity to include obesity prevention, increased fruit and vegetable consumption, increases in physical activity and breastfeeding and reduced TV time.				X
2. Contract with the University of North Texas Health Science Center to conduct social marketing research to develop messages to use with the implementation of the "Strategic Plan for the Prevention of Obesity in Texas."				X
3.				
4.				
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9.				
10.				

b. Current Activities

Activity 1: Working with statewide partners, TDH staff will develop an Implementation Guide for the Strategic Plan for the Prevention of Obesity in Texas. The Implementation Guide is planned to target communities, schools, businesses, and other organizations interested in identifying obesity-prevention activities that they may be able to implement at their level.

Update: A decision was made during this report period to revise the existing Strategic Plan for the Prevention of Obesity in Texas rather than develop a separate implementation guide. In the DSHS consolidation, the Nutrition, Physical Activity and Obesity Prevention program staff are now coordinating this process. Program staff discussed a revision plan and consulted with the University of Texas Department of Kinesiology and Health Education to seek assistance in finding a writer/facilitator for the revision project. The current work plan and timeline include identification of needed partnerships and a writer, generation of content for the strategic plan revision, review of the plan by stakeholders and DSHS programs and a final draft by December, 2005. The original release date of August, 2005, will be delayed due to DSHS consolidation efforts. The new release date is April, 2006, and will occur in conjunction with the Texas Public Health Association's annual conference.

Activity 2: Working with the Goal A Workgroup of the Texas State Health Strategic Partnership, develop a comprehensive distribution plan for distributing the Implementation Guide.

Update: Two members of the Obesity Prevention team helped facilitate the Goal A Workgroup's annual meeting in October, 2004. Goal A of the Texas Strategic Health Partnership is to improve the health of all Texans by promoting healthy nutrition and safe physical activity. The Comprehensive Plan was discussed at this meeting and Goal A members that were interested in participating in the process were asked to fill out a questionnaire that will help facilitate partner input. A distribution plan for the Comprehensive Plan was not discussed at this meeting; however, it will be a topic of conversation in March, 2005. Since the October, 2004,

meeting occurred, the decision was made to revise the Strategic Plan for the Prevention of Obesity in Texas instead of developing an implementation guide.

c. Plan for the Coming Year

Activity 1: Work with WIC to describe the food consumption patterns found from the Toddler Epidemiological Study conducted by the University of Texas at Austin.
Output Measure: Number of children enrolled in study; demographic data of participating children; number of children with BMI>30; percent of toddlers consuming different food types and frequency; percent of each of the foods consumed by toddlers.
Monitoring: Document survey's implementation progress.

Activity 2: Work with the WIC program to assess the effectiveness of the "Fit Families" Program on increasing knowledge and impacting behavior among women and children in the WIC participating clinic sites.
Output Measure: Number of women enrolled in "Fit Families" program; average number of women attending each "Fit Families" class; number and topic of classes provided; number of pre-test surveys completed; number of post-test surveys completed, number of post-test surveys showing increased knowledge and positive behavioral change after participating in the "Fit Families" program.
Monitoring: Document class attendance; review pre- and posttest surveys.

Activity 3: Collaborate with the School Physical Activity Nutrition (SPAN) group to collect data on demographics, nutrition behaviors, attitude and knowledge, and physical activity behaviors among 4th, 8th, and 11th grade children.
Output Measure: Prevalence of overweight among Texas school children by grade, gender and race/ethnicity.
Monitoring: Follow-up the development and implementation of the Survey of Texas Public Schools.

State Performance Measure 6: *Incidence of carious lesions among 3rd to 7th grade children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43	43	43	43	43
Annual Indicator	49.9	49.9	43.2	31.3	66.3
Numerator	3289	2960	8092	5598	7892
Denominator	6596	5936	18735	17874	11902
Is the Data Provisional or Final?				Final	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	43	43	43	43	43

Notes - 2003

SOurces:
TDH, Texas Statewide Dental Survey, 1997-2002
TDH Oral Health Program Annual Report FY 2003

a. Last Year's Accomplishments

Activity 1: Conduct statewide survey of caries prevalence among school children in Texas.

Update: In FY04, DSHS regional dental teams examined 11,902 school children statewide and found that 7,892 or 66% had caries present. Parents were notified of presence of dental caries and advised to follow-up with the family dentist.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available

Update: In FY04, a total of $134,137 in grants was awarded to upgrade equipment at six water systems in East Texas and the Gulf Coast area and to provide fluoridation equipment to one new system in East Texas (Jasper City). In addition, engineering system designs were completed and supplied for each grantee. Fluoridation system designs were also provided at no charge to six non-grantee water systems, including the San Antonio Water System, Bexar Met, and other Central Texas locations in the greater Austin area. Program staff inspected 80 of the public water systems that fluoridate and conducted seven operator training classes offering continuing education credits. A total of 168 water operators attended the classes, which focused on the benefits of water fluoridation, chemical safety, equipment design, and testing procedures. The program is also continuing to add, correct, and validate fluoridation data through the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS).

Performance assessment: Of the population screened in FY04 (children in the free and reduced lunch program), there were 7,892, or 66%, third to seventh-grade children with dental caries. Part of the increase may be attributable to increased screening efforts by the DSHS Oral Health Program. The state target is 43%. FY04 data indicate a clear need for access to dental care for these children. FY06 activities include a continuation of DSHS regional dental teams, establishment of a state coalition for oral health through water fluoridation and sealants, and provision of training to local fluoridation water system operators.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct statewide survey of caries prevalence among school children in Texas.				X
2. Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provdide upgrades to existing flouridation systems at the community level if funding is available.				X
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Conduct statewide survey of caries prevalence among pre-school and or school age children in Texas.

Update: Regional staff received calibration training in May 2004 to assure that all were using the same methodology when conducting the Association of State and Territorial Dental Directors Basic Screening Survey. From September, 2004, through February, 2005, DSHS regional dental teams examined 11,127 school children statewide and found that 45% had caries present. Parents are notified of presence of dental caries and are advised to follow-up with their family dentist.

Activity 2: Promote the health benefits of community water fluoridation, maintain existing fluoridation systems, and provide upgrades to existing fluoridation systems at the community level if funding is available

Update: During the first two quarters of 2005, the Texas Drinking Water Fluoridation Project (TDWFP) worked on system designs for proposed grants that total of $131,877. Program staff made 26 inspection trips to public water systems that fluoridate. Letters were sent to 192 systems that fluoridate requesting their participation in a monthly fluoridation monitoring system. Monthly report data were reported to the Centers for Disease Control and Prevention Water Fluoridation Reporting System (WFRS). The program is also continuing to add, correct, and validate fluoridation data contained in the WFRS database.

c. Plan for the Coming Year

State performance measure 6, the incidence of carious lesions among 3rd to 7th grade children, is not carried over in FY06.

State Performance Measure 7: *Percent of female clients suspected of being victims of relationship abuse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3.9	3.8	3.8	3.7	3.7
Annual Indicator	3.8	3.7	3.8	3.8	3.7

Numerator	12425	12110	12082	12683	11188
Denominator	328327	323789	316875	331439	303819
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.6	3.6	3.6	3.6	3.6

Notes - 2003

Sources
DPS Uniform Crime Reporting: Family Violence Incidents
http://www.txdps.state.tx.us/crimereports/02/ch5.pdf
SP213S Report for TXX; FPAR Report for Title X; Title V MCH Services Data Summary, 1996-2001

FPAR Report 2003 for Title V, Title X & Title XX (K:/Data/Family Planning/Data Requests/Open Records Request/02.2004

a. Last Year's Accomplishments

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Update: Title V staff continue to distribute educational materials and other items on family violence/sexual abuse prevention that include posters and brochures, which are gender-specific. A total of over 600 individual posters and brochures were distributed. Thirteen entities requested additional materials..

Activity 2: Through the program website, continue providing accessible abuse prevention and youth development training to Title V providers, DSHS regional offices, and other interested parties.

Update: In January, 2004, program staff completed the first training module on sexual coercion. There were 94 hits to the training module website. In FY04, the module was located on a password protected section of the website, but the site will be marketed to all women's health providers in the future.

Activity 3: Implement the statewide strategic plan to prevent violence against women.

Update: The Violence Against Women Prevention Advisory Committee (VAWPAC) was formed in 2003 to coordinate planning among partners involved in prevention of violence against women. A Strategic Plan to Prevent Violence Against Women was developed by the VAWPAC and approved at DSHS on January 9, 2004. Also in January 2004, leadership of VAWPAC was transferred to the Texas Association Against Sexual Assault, and the VAWPAC changed its name to the Interpersonal Violence Prevention Collaborative (IVPC). The role of DSHS is now advisory. In November, 2003, IVPC received a $10,000 grant from Texas Health Resources. The workgroup proposed that partial funding be used to hire a grant writer to secure additional funds for an executive director to oversee the implementation of the strategic plan. The grant writer was hired in February, 2004.

Performance assessment: FY04 projected data is that 3.7% of female clients were suspected of being victims of relationship abuse, a slight decrease from 3.8% in FY03 and FY02. Data continue to show no significant improvements over past year, perhaps validating the difficulty in

addressing the breadth of this issue. Activities planned for FY06 include increasing the number of referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Interventions Program, increasing the number of successful collaboratives to reduce violence against women in DSHS health service regions, and development of a web page for providers that focuses on violence prevention.

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Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.			X	
2. Through the program website, continue providing accessible abuse prevention and youth development training to Title V providers, DSHS regional offices, and other interested parties.				X
3. Implement the statewide strategic plan to prevent violence against women.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Activity 1: Distribute family violence/sexual abuse prevention educational materials designed for Title V and other interested health care providers.

Update: Materials are now distributed through the DSHS warehouse. Brochures and posters are gender-specific. A total of 5,888 brochures and posters for females were distributed through May 5, 2005. No poster or brochures were distributed for males.

Activity 2: Through the program website, continue providing accessible abuse prevention and youth development training to Title V providers, TDH regional offices, and other interested parties.

Update: From September, 2004, through May, 2005, there were 113 hits to the Sexual

Coercion Website. The website module offering training to providers on youth development and abuse prevention was temporarily disabled but will be reposted and will be open to all providers.

Activity 3: Implement the statewide strategic plan to prevent violence against women.

Update: In September, 2004, representatives from Department of State Health Services (DSHS), the Texas Council on Family Violence and the Texas Association Against Sexual Assault attended the CDC sponsored PREVENT conference for further education on violence against women prevention strategic planning.

Under the direction of the DSHS Title V program, four Texas Health and Human Services agencies, including DSHS the Department of Assistive and Rehabilitative services, Department of Family and Protective Services and the Department of Aging and Disabilities met with members of the Interpersonal Violence Prevention Collaborative (IVPC, formerly the Violence Against Women Prevention Advisory Committee) met on December 10, 2004 and agreed to implement elements of the Strategic Plan. The statewide plan was accepted and implementation has begun.

c. Plan for the Coming Year

Activity 1: Increase the number of successful referrals that occur as a result of screening for abuse in the Pregnant and Post-Partum Intervention Programs (PPI).
Output Measure(s): Number of women participating in PPI, number of women who answered yes to the PPI risk assessment question about abuse by family or significant others; number referred for domestic violence services; number for which a client consent and client consent follow-up form is completed and were monitored for client follow-through.
Monitoring: Review and document progress through bi-annual summary report of the PPI data.

Activity 2: Increase the number of successful collaborative activities to reduce violence against women in DSHS health service regions.
Output Measure(s): Number and type of collaborative activities implemented in each DSHS health service region to reduce violence against women.
Monitoring: Follow-up and review quarterly reports from health service regions.

Activity 3: Develop and promote DSHS Web Page that focuses on Violence Against Women that is available to all public health providers. Included on this site will be a distance learning opportunity titled "The Prevention of Sexual Coercion Among Adolescents." Screening tools and information are also available.

Output Measure(s): E-mail notification sent to all DSHS women's health contractors, number of hits to the website; number of training completed on the distance learning page; summary report on the usefulness of the website.
Monitoring: Follow-up progress on website development; track the number of hits to the website and the distance learning page, review summary reports of survey results on the usefulness of the website.

E. OTHER PROGRAM ACTIVITIES

Sudden Infant Death Syndrome (SIDS): The Title V Program administers an autopsy reimbursement program mandated by Texas statute that allows counties to claim a fixed reimbursement toward the cost of an autopsy where the cause of death is determined to be SIDS. The program also provides a mechanism to track SIDS deaths, maintain a database that includes demographic information on the

case and develop a better understanding of the circumstances that surround SIDS. In FY 03, Title V staff worked with a state-level workgroup to develop and present a workshop on infant mortality. A possible future activity for Title V staff is training stakeholders from areas with the highest incidence of SIDS.

Child Fatality Review: Texas has 46 local child fatality review teams (CFRTs) that review child deaths, identify gaps in service and agency coordination and develop community programs and activities to reduce the incidence of preventable child deaths. Data are collected and sent to DSHS for analysis, and aggregated data are used to identify statewide trends and prevention strategies likely to reduce preventable child deaths.

The Texas Child Fatality Review Team State Committee is charged with developing a better understanding of the causes and incidence of child deaths, promoting public awareness, making recommendations for changes in law, policy, and practices in order to reduce the number of preventable child deaths, and supporting the local CFRTs through technical assistance and networking. DSHS and the Department of Family and Protective Services (DFPS) jointly lead the State Committee. Legislation that passed during the 79th Texas Legislature moves the Committee leadership to DSHS. The feasibility of placing the Committee in the Title V program is being considered.

During the 79th Texas Legislature, there were discussions on creating a Fetal-Infant Mortality Review (FIMR) process. While the legislation did not pass, it is clear that information gained from a thorough, competent FIMR process enhances understanding of fetal and infant mortality and child deaths. DSHS staff are also looking at opportunities to integrate the FIMR process into the CFRT structure. Toll-Free Hotline--2-1-1 Texas (2-1-1): As part of the HB 2292 Consolidation Act, many local and statewide health and human services toll free hotlines in Texas were centralized. The purpose was to minimize duplication, facilitate accessing information for the consumer, standardize the content and quality of the information provided, and reduce costs. Previously, Title V had multiple toll-free lines based on the various program areas including the Family Health Services toll-free line. In November 2004, most of the services provided by the Family Health Services toll-free hotline were transferred to 2-1-1 to provide callers with information about services offered by nonprofit and faith-based organizations and government agencies. The centralization of these lines enables consumers to easily access information. The service is provided through a public/private collaboration of the United Way and other community-based organizations and the Texas Health and Human Services Commission (HHSC). The state is divided into 25 Area Information Centers (AICs) that are networked to enable access to each other and to allow higher volume AICs to take calls for lower volume AICs as needed. The whole system can also mobilized to provide information and updates during times of emergency or during significant public health events.

The 2-1-1 line is available 24 hours a day, seven days a week and is accessible in multiple languages and by text telephone, or TTY. The language services are provided either by Tele-Interpreter or the AT&T Language Line. Title V and other DSHS staff routinely provide referral sources, such as contractors, to update the 2-1-1 database.

Referrals provided through 2-1-1 include assistance programs such as Medicaid, Medical Transportation, Food Stamps, TANF, WIC, Title V and other social services; service providers, including Early Childhood Intervention, immunization, substance abuse, mental illness, and mental retardation; Texas Special Education information; job training for persons with disabilities through the Texas Rehabilitation Commission; referral to licensed child-care facilities; resources for food, clothing, housing, education; and parenting classes.

As part of the transition, DSHS staff met with HHSC and 2-1-1 staff to review the capacity of 2-1-1. The decision was to continue a toll-free DSHS line so 2-1-1 could refer certain types of calls to DSHS. These calls include health screening programs and CSHCN.

From September to November 2004, 2,028 calls were received and 2,571 referrals were made

through the Family Health Services line. After that, 2-1-1 became responsible for data collection. From December 2004 to May 2005, 2-1-1 handled 39,377 maternal and child health-related calls. The highest number of referrals was for medical expense assistance, followed by dental care and outpatient mental health care. This increase may be due to the simplicity of the number, the multi-lingual capacity, and the broader array of information and referral sources. The 2-1-1 System is growing through software enhancement and expanded data collection capabilities. Title V and 2-1-1 staff have collaborated to assure that Title V needs assessment data are routinely collected.

National Women's Health Week (NWHW): Title V staff promoted the 2005 NWHW by informing contractors of the opportunity to develop activities focusing on women's health and serving as a resource for those who participated. Title V staff also worked with the Cardiovascular Health and Wellness Program to present an activity at DSHS.

F. TECHNICAL ASSISTANCE

The population diversity, economy, and health needs of Texas continue to evolve in an environment for which resources continue to diminish, requiring an infrastructure that is effective and efficient. Consideration of the technical assistance needs described on Form 15 will enhance the state Title V program's efforts to meet the challenge of improving the health of the MCH population. Form 15 identifies the key areas for which Texas is requesting technical assistance.

Item 1 is related to NPM 9 for oral health. While nationally there is increasing recognition of the importance of early screening and referral for preventive care in the oral health of children, there remains a need to enhance access to such care. Currently, a limited number of pediatric and general dentists possesses the background and training to offer and/or provide this service. In Texas, practicing pediatric dentists are small in number and are concentrated in a limited number of urban counties. In order to meet the needs of young children, Texas requests technical assistance and funding to identify best practices related to providing and promoting preventive oral health care, including sealants, for children under 5, a plan for implementing training for providers on oral health screening/care to young children as well as enhancing awareness of caregivers regarding the importance of early preventive oral health care.

Items 2 and 3 are related to NPM 15, low birth weight infants and NPM 18, early prenatal care, specifically for the significant disparities that continue to exist for African American women. Although the Title V program activity plan for FY06 will target the population and areas of the state where low birth weights and low utilization of early prenatal care exist, Texas would benefit from technical assistance to identify low-cost yet effective strategies that would positively impact these two national measures and ultimately the outcome measures that continue to be a challenge. Those outcomes measures are infant mortality (OM #1), neonatal mortality (OM #3), perinatal mortality (OM #5), and, specifically related to the African American health disparity, the ratios of black infant mortality (OM #2) and perinatal infant mortality (OM #7) to that of whites. Texas data for these disparities mirror national data but there is no clear explanation for the disparities. However, research indicates that although early and adequate prenatal care is the primary approach to resolve the disparity, strategies designed to enroll and provide the care must meet the specific needs of the target population. Life Course Perspective is an evidence-based intervention model that specifically addresses this disparity by focusing on the overall health status of women, with special emphasis on the critical factors of inflammation, infection and stress. With technical assistance to design and implement this type of model, the Texas Title V program may be able to positively impact the health disparities in low birth weights and prenatal care for African American women.

Item 4 relates to improving the Texas Immunization Program's technical assistance materials and methods. Improvement in this infrastructure could positively impact immunization rates in Texas (NPM 7) and ultimately all of the national and state outcome measures. The DSHS Immunization Program requests assistance in use of the program website as an effective technical assistance tool; for an external evaluation of customer service provision through the DSHS central office, the DSHS health

service regions, and local health departments; and an external evaluation of publications used to provide technical assistance to the public, to healthcare providers, and to contractors around the state.

Item 5 is related to NPM 1 for newborn screening expansion. Pursuant to Legislation (House Bill 790) passed in the recently completed 79th Legislative Regular Session, DSHS will be looking to expand the panel of inheritable disorders screened in Texas. While expanding the screening, Texas also needs to consider the establishment of regionally-based contracts to assist with the follow-up, confirmatory testing and treatment of children who screen initially positive for the expanded list of disorders. Literature reviews indicate that often Title V is a source of additional funding to enhance newborn screening programs across the nation (Financing State Newborn Screening Systems in an Era of Change, Association of State and Territorial Health Officials, March 2005). Texas requests technical assistance resources to determine the feasibility of establishing regionally-based providers, educating them on the expanded disorders, and funding the follow-up, confirmatory testing and treatment of identified children in Texas.

V. BUDGET NARRATIVE

A. EXPENDITURES

Forms 3, 4, and 5 show variations in expenditure amounts, which could be explained by the Title V budget realignment conducted for FY 02 and FY 03, directives from recent legislative sessions, the impact of CHIP, and the re-directing of Title V funds to accommodate specific MCH population needs.

Form 3 shows a variation in expenditures between FY 01 and FY 04. The expenditure level decreased from $107,287,294 in FY 01 to $85,078,798 in FY 04, representing about 21% variation. A portion of this decrease is attributed to a reduction in Title V state funds by an estimated of $7.8 million and $4.5 million in FY 02 and FY 03, respectively. This budget re-alignment effort was necessary because the Title V MCH program budgeted for services over and above the annual state and federal appropriations for some time. In addition, the 77th Legislative Session mandated Title V MCH and CSHCN programs to transfer state general revenue funds to CHIP and the Interagency Council on Early Childhood Intervention.

Form 3 also shows a carryforward of about $10 million from FY 05 into FY 06. One of many contributing factors could be the impact of CHIP. Expenditures on children between the ages of 1 and 22 vary greatly from $26,149,744 in FY 01 to $18,467,367 in FY04. Title V-funded contractors are required to screen children for potential Medicaid and CHIP eligibility prior to determining Title V eligibility and to spend at least 25% of their Title V amounts on children. Many of the contractors are experiencing difficulties in achieving the 25% requirement because a number of children who used to receive Title V child health services currently are covered by CHIP.

In addition, this carryforward could not be used alone to remove additional children from the CSHCN waiting list since this funding is available only one time. In other words, the CSHCN program could not sustain similar capacity to cover expenditures for all these children beyond FY 05. Another contributing factor is that the CSHCN program must notify the Legislative Budget Board and Governor at least 30 days prior to adding clients from the waiting lists to the program rolls. This mandated procedure has caused delays in moving children from the waiting list. Fortunately, the recently completed 79th Legislative Regular Session has changed the 30-day notification to 15 days, effective September 1, 2005.

The characteristics of the population served by the CSHSCN program contribute greatly in the significant variations in client expenditures from year to year. DSHS regularly analyzes the CSHCN Program client expenditures to operate within budget limitations. In FY 04, projected expenditures based on historical utilization data were greater than incurred costs to the state. As appropriate, funds were carried forward to FY 05 to allow additional children to be removed from the existing waiting list for the CSHCN Services Program's health care benefits. Projected costs vary due to differences in client access and utilization of third party coverage (i.e., Titles XIX, XXI, or private insurance); the wide array of possible diagnoses allowed within the eligibility criteria; and the unique medical needs of children with similar diagnoses.

Form 4 shows variations in the expenditures across MCH population types. Pregnant women, as well as infants under 1 year old, remain stable between FY 01 and FY 04. The expenditure levels between FY 01 and FY 04 are $ 18.1 million and $17.4 for pregnant women, and $188,643 and $170,750 for infants under 1 year old. These slight variations in expenditures for pregnant women and infants less than 1 year old can be attributed to the FY 02 & FY 03 Title V budget re-alignment.

Expenditures for CSHCN decreased from $41,346,111 in FY 01 to $29,608,981 in FY 04. This decrease can be attributed to two main raisons: 1) Title V was asked by the 77th Legislative Session to transfer one-time only $7 million in Title V funds to the Interagency Council on Early Childhood Intervention (ECI), which provides a coordinated system of services available in every Texas county for children, birth through age 3, with disabilities or delays; and 2) CSHCN program was mandated by the same legislative session to commit state general revenues funds of $3 million in FY 02 and $10

million in FY 03 as savings acquired due to CSHCN being covered by CHIP and Medicaid programs.

Form 5 indicates significant variation in expenditures by types of service. As result of the decrease in total expenditures of $107,287,294 in FY 01 to $85,078,796 in FY 04, every category (i.e., direct health care services, enabling services, population-based services, and infrastructure building services) experienced decreases in expenditures. The rationale behind these expenditure variations was addressed in Forms 3 & 4 budget justifications.

B. BUDGET

Maintenance of Effort and Continuation Funding

Texas will continue to provide the maintenance of effort (MOE) amount of $40,208,728. This represents more than $10 million in excess of the state matching rate of $3 state dollars for every $4 federal dollars. In addition, Texas continues to provide funding for service categories funded under Title V prior to 1981, including: 1) children with special health care needs services; 2) case management for SSI-eligible children; 3) genetics services; 4) SIDS prevention activities; and 5) family planning and teen pregnancy prevention services.

30% - 30% Federal Requirement
The Title V program makes good faith efforts to comply with allocating and spending at least 30% of the federal allotment for preventive and primary services for children and at least 30% for specialized services for children with special health care. To achieve the 30% -30% requirement, the Title V contracts program requires all MCH Title V-funded contractors to provide child health services in the amount of at least 25% of the contracted amount. The Title V program funding supports accountants within the DSHS Budget Office whose primary responsibilities are to set-up proper accounting and financial practices in managing the Title V budget in general, and particularly, to establish internal controls to monitor expenditures of federal funds. The Budget Office's Grants Coordination and Funds Management Unit prepares financial reports on progress vis-a-vis compliance with the 30% - 30% requirement on a quarterly basis. Title V program leadership reviews reports and provides feedback as needed.

For FY 06, Form 2 shows that $11,272,213 (or 30% of the estimated federal award) has been budgeted for children and adolescents and an additional $11,272,213 for children with special care needs. The same vigorous monitoring process is in place to comply with the 10% administration cap. The latter is budgeted at $3,757,404, as shown in Form 2.

Other Sources of Funding for Women and Children
Texas receives other federal, state, and private grants related to women and children. These grants include: 1) MCHB - State Systems Development Initiative; 2) MCHB - Abstinence Education; 3) MCHB - Integrated Comprehensive Women's Health Services; 4) MCHB - State Early Childhood Comprehensive Systems; 5) Centers for Disease Control and Prevention - Breast and Cervical Cancer Control Program; 6) Support State Oral Disease Prevention Program; 7) Texas Cancer Council - regional school health specialists; 8) Title X State Coordinated Family Planning Project; 9) CDC Pregnancy Risk Assessment Monitoring System; 10) WIC (Farmers Market, Electronic Benefit Transfer, Breastfeeding Peer Counseling); 11) Chronic Disease Prevention and Health promotion-Obesity Component; and 12) HRSA Cooperative Agreement for Primary Care Services & Manpower Placement.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.